

FINAL EVALUATION

CATHOLIC RELIEF SERVICES/ETHIOPIA

TITLE II PROGRAMS

MYOP 1994-1996

Evaluation Team:

Joyce King, Team Leader, MCH Consultant
Mamo Mulat, Agriculture and Natural Resources Consultant

Assisted by:

CRS/Ethiopia Technical Staff

Amsalu Gebre Selassie, Manager for Title II Program
Emebet Admassu, MCH Program Coordinator
Wondimu Haile Mariam, OCF/GR Program Coordinator
Moges Worku, Ag/NR Program Coordinator
Mesele Endalew, Ag/NR Program Coordinator

Field work in Ethiopia, November 23-December 14, 1995

TABLE OF CONTENTS

EXECUTIVE SUMMARY	ii
ACRONYMS AND GLOSSARY.....	v
CHAPTER ONE:	
THE PURPOSE AND BACKGROUND OF THE EVALUATION	1
CHAPTER TWO:	
THE CRS INTERVENTIONS: TECHNICAL AND SOCIO ECONOMICS ASPECTS	3
The Maternal Child Health Program	3
The Women's Credit Program	17
The Food for Work and Cash for Work Programs.....	19
Other Child Feeding and General Relief	28
CHAPTER THREE:	
CONCLUSIONS AND RECOMMENDATIONS	30
The Maternal Child Health Program	30
The Women's Credit Program	38
The Food for Work and Cash for Work Programs.....	40
Other Child Feeding and General Relief	42
APPENDICES (Numbered separately)	1
Methodology	2
Work Plan	4
Questionnaires	5
Persons Consulted	15
Documents Consulted	20

EXECUTIVE SUMMARY

This final external evaluation assesses Catholic Relief Services (CRS) program in Ethiopia during Fiscal Years 1994-96. Ethiopia has been a major emphasis country for CRS since the severe famine years beginning in 1985 when many countries of the world responded to the massive scale relief needs (CRS initially started a program in Ethiopia in 1958). CRS/Ethiopia (CRS/ET) was a leading participant in these relief operations and with its counterparts responded to the requests of the new government installed in 1991 to transform relief feeding into development/work programs. Moreover, answering its own mandate and that of the new Food Security legislation and USAID policy interpretations, CRS/ET has been intent in recasting its programs to demonstrate measurable benefits on the health and well-being of the Ethiopian people. This process with its call for monitoring and evaluation (M&E) which, except for a nutritional status surveillance system for Maternal Child Health (MCH) inherited from the Africa region, was given secondary attention while the focus was on meeting delivery targets to specified numbers of recipients. CRS/ET has concentrated on building an awareness within its own organization and its counterparts who are its operational arm on how the food security mandate can be implemented in Ethiopia. Over the past year, the CRS/ET mission has established and guided task forces to study the central issues of integration, sustainability and institution-building, has prepared strategic statements and called upon technical counsellors in the region and in Baltimore (including agricultural, MCH/child survival and food security advisers appointed over the last year or two), to provide guidance and input for the preparation of its upcoming Development Activity Proposal (DAP) which it will be presenting to USAID/Washington in the summer of 1996. CRS/ET leadership are earnestly conceptualizing and aggressively reshaping their program into a developmental one that will realize demonstrable impact. A well prepared technical staff has been intimately involved with the conceptualization and redesign process, taking part with management in months of brainstorming, reorientation and cautious selection, and as necessary deselection of counterparts in a manner that will ensure that future key players have developmental capability and conviction.

The CRS/ET emergency relief program has been greatly reduced from a high of 72,000 metric tons (MT) in 1994/95 to 18,640 MT in 1995/96. In addition to emergency food, it now programs approximately 21,000 MT annually of Title II food for development programs (subject of this evaluation). More than half of the food assistance goes to more than 20 MCH centers serving 3000 children, pregnant women and mothers each, and for more than a million man days of Food for Work jobs. Continuing to reflect its past profile of relief feeding, a large portion (nearly half) goes to the Missionaries of Charity, General Relief and Other Child Feeding. The programs are located in central and eastern Ethiopia, in Eastern and Western Shewa, Oromia, Gurage and Hararghe. Principal counterparts are the Nazareth Children's and Integrated Community Development (NACID), Hararghe Catholic Secretariat (HCS), Archdiocesan Catholic Secretariat (ACS), Missionaries of Charity, Cheshire Foundation, Meki Vicariate, Wonji and Metehara Catholic Missions, and Integrated Holistic Approach (IHA).

The rubric "Other Child Feeding" (OCF) in fact masks several activities that are integrated development programs which change the status of beneficiaries by improving the nutritional status of children, by preparing young people for jobs through schooling and/or vocational training, or which are food for work activities which build infrastructure and contribute to food security. These activities should be programmed separately from the otherwise welfare categories. The remaining programs in OCF and General Welfare either need to be restructured as institution-building efforts (some are relatively new and constitute what has been called "a fragile social safety net" for the poorest in Ethiopia, but they need strengthening and help with broadening their donor base) or risk being phased out under USAID's food security guidelines. It is suggested that CRS/ET develop an institution building strategy, in collaboration with local church and institution leaders, which continues to support these welfare efforts while at the same time building their donor base so that USG food assistance can be eventually phased out. This will minimize the negative effects of precipitously withdrawing critical food assistance for the most needy.

Major new directions have already been plotted for the MCH/Women's Credit and FFW/CFW programs. The programs will be linked by integrated mini-catchment geographical units with community-based health services and programs that improve water supply, food production and access. The MCH programs have already moved impressively to preventive health for the most vulnerable--under two year old children and pregnant women. Benchmarks for preventing growth faltering have been realized. Overall rates of malnutrition in the 10 centers visited have declined from rates found by Teller et al in their 1992 evaluation--from 84% among under four year old children to 46% among under three year old children. Severe malnutrition dropped from 16% to 2.3%. However, lack of control groups makes it impossible to attribute these changes to the program. (External factors may have caused the improvement.) Linkages with medical clinics have been strengthened to ensure that children and pregnant mothers have up-to-date immunizations and checkups, and are referred for medical attention if necessary. Pregnant women are being enrolled in the program, a rare achievement in worldwide MCH programs. Baseline surveys on mothers' knowledge and practices have been completed in two centers and will be extended to other centers and based on these results, the education content will be revised. It has been further recommended that greater participation from mothers be obtained and that more knowledge of current traditional practices is needed for more effective mother education. It is recommended that CRS/ET consider nutritional status monitoring and evaluation indicators as well as growth faltering, immunization rates and mother knowledge and practices and that detailed studies of existing data be used to set targets for age groups.

Starting off as an adjunct to the MCH program is a very successfully launched Women's Credit program which is still in its infancy but showing positive indications of nearly 100% repayment rates, increasing profits with subsequent larger second and third loans and unknown but potential benefits on household food security especially qualitatively.

It has been suggested that women might be encouraged to try out some new trade areas particularly ones that could complement MCH programs--producing weaning mixes, e.g., which have already been piloted as income generating schemes by Caritas. Further it is recommended that an M&E indicator be identified that will measure the extent to which profits are used for food expenditures.

Food for Work/Cash for Work programs have targeted the poor and provided jobs as their primary purpose. Projects to correct soil degradation have longer term impact insofar as improving agricultural productivity but have also had important early effects on ecosystems and farmer awareness. Moreover, there have been short-term benefits from improved water supply whether for livestock, human consumption or small-scale irrigation. Grasses that hold the soil also are harvested for forage. Future FFW/CFW activities will stress: integration of effort within well-defined, more concentrated catchment areas; inputs that ensure short-term benefits to crop yield (loans for fertilizers, improved seeds, better irrigation systems); and consideration of project assets will have priority over simply helping poor families. Technical aspects of the projects were inadequate for the most part but it was suggested that the demonstration models may be very complex and research-oriented while more practical models might be promoting research proven crop varieties for rapid adoption by farmers.

CRS/ET has taken most of the decisions: assigned task forces to study different food security components, carried out strategic planning, consulted with regional and headquarters technical experts about project areas. These planning efforts are expected to result in a very different portfolio profile, moving the agency away from what has been a strong humanitarian, egalitarian stance with scattered relief cum development activities. The new look will not desert the poorest who will continue to be the focus of CRS/ET targeting, but the projects will be more carefully designed, integrated, concentrated programs in areas with development-oriented leadership whose benefits can be measured thanks to baseline and follow up surveys and a monitoring and evaluation strategy and then move on to new areas before dependencies on both counterparts and beneficiaries occur. The 1994-96 record demonstrates the ability of the agency to transform itself and the foundation itself for these changes.

ACRONYMS AND GLOSSARY

ACS	Archdiocesan Catholic Secretariat
AER	Annual Estimate of Requirements
Birr	Ethiopian currency (exchange rate early December 1995, \$1 =6.25 Birr)
CDPP	Commission of Disaster Prevention and Preparedness
CFW	Cash for Work
CRS/ET	CRS/Ethiopia
CSB	Corn Soya Blend
DAP	Development Activity Proposal
DELTA	Development Education and Leadership Training in Action (based on the Paolo Freire participatory model developed earlier)
ECS	Ethiopian Catholic Secretariat
FFW	Food for Work
Fanya Juu	Literally means "shovelling the soil uphill". It differs from normal bunds which shovel the soil downhill
GM	Growth Monitoring
GR	General Relief
GS	Growth Surveillance
HCS	Hararghe Catholic Secretariat
IHA	Integrated Holistic Approach
JRP	Joint Relief Partnership
KPC	Knowledge, Practices and Coverage
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MOA	Ministry of Agriculture
MOC	Missionaries of Charity (founded by Mother Theresa for urban destitute)
MYOP	Multi-Year Operational Plan
NACID	Nazareth Children's Center and Integrated Community Development
NGO	Non Governmental Organizations
OCF	Other Child Feeding
RRC	Relief and Rehabilitation Commission (recently renamed the Commission Disaster Prevention and Preparedness - CDPP)
USAID	United States Agency for International Developmentof
WA	Weight for age (one of the anthropometric indicators of child growth progress)
WID	Women in Development
WSB	Wheat Soya Blend

CHAPTER ONE: PURPOSE AND BACKGROUND OF THE EVALUATION

Purposes of the Evaluation. The purposes are to assess whether CRS/Ethiopia food-assisted programs have been successfully implemented as planned during the Multi-Year Operational Plan (MYOP) period FY 1994-96, or October 1993 to September 1996 and according to their intended goals and objectives; to identify the shortcomings of the program which are specific to CRS/Ethiopia and/or in general terms; to draw lessons from these programs in order to improve the effectiveness of development projects; and to fulfil donor's and CRS' requirements.

General CRS Background. CRS operates Title II food programs in 18 countries. Nearly 4 million beneficiaries receive Title II commodities in programs from emergency relief and rehabilitation (7 countries) to activities meeting food security needs of specifically targeted populations (14 countries). CRS non-emergency interventions are designed to support segments of the population most vulnerable to food insecurity by operating programs in MCH and nutritional rehabilitation for children, school feeding, food or cash for work, and other child feeding and general relief within and without institutions. During the 1960s, there were massive distributions under the Alliance for Progress; the focus was on delivery of commodities to the poor. During that period, improving accountability and logistics were immense challenges. Although effective management of food resources remains a program priority in difficult overseas environments, increasing attention is being paid to maximizing impact of commodities on the lives of the poor. CRS is committed to the principles that PL480 programming must increase food security for households and vulnerable individuals, foster greater self-reliance and promote sustainable improvements in the situation of the poor.

Ethiopia Setting. CRS/ET is a program in transition, a process which began in great seriousness a year ago when massive scale emergency programs were winding down and, in a less strife-ridden setting, possibilities to develop development programs became feasible. In a first post-emergency phase, and in the wake of an overnight government policy decision in late 1994 to end relief feeding and replace it with "relief Food for Work" programs, CRS/ET's counterparts responded quickly in recasting its activities. Noting the role of CRS/ET to be non-operational and dependent on counterparts to implement field activities, the agency nevertheless plays a prescriptive role in getting counterparts to take on the specialist staff needed to craft and direct sound technical programs, whether agricultural, soil conservation or water development scientists or health coordinators, and in seeing that programs are integrated and focused within a relatively circumscribed area. Thus the highly scattered activities of the past are increasingly closely kneaded into nuclei of projects. Not only are these new projects confined to smaller geographical space, but they are time-bound in order to permit greater coverage in the longer term. In the next project design, the 1997 - 2001 Development Activity Proposal (DAP), the counterpart network is being dramatically altered into concentrated development activity masses.

Plan of Work and Methods. The two-member team consisting of an expatriate team leader with expertise in nutrition and MCH and worldwide experience with food aid programs, and a natural resources soil conservation expert with field experience in the Agriculture Ministry of Ethiopia and FAO evaluation experience, worked in the country November 23-December 14, 1995, visiting program sites in principal CRS/ET counterpart areas. Following this field work, an informal presentation of preliminary findings and recommendations were provided to CRS/ET. The written report was completed on January 2 and sent by DHL to CRS/ET for comments, after which this final report was prepared.

CRS/ET's MYOP for 1994-96 and updates for 1995 and 1996 were used as a general reference point for evaluating achievements against planned targets. The principal programs reviewed were the maternal child health (MCH) program, the credit program, the food for work (FFW) and cash for work (CFW) programs and the general relief (GR) and other child feeding (OCF) programs. MCH and credit programs were studied in all of the counterpart areas of operation: NACID in Nazareth, Cheshire in Addis, the Hararghe Catholic Secretariat (HCS) in Dire Dawa, the Archdiocesan Catholic Secretariat (ACS) in Gurage, and the Meki Vicariate and Wonji Catholic Church in East Shewa zone.. The FFW/CFW program sites were visited in Nazareth, HCS (Dire Dawa, Kombolcha, Fedis and Jarso) and ACS (Emdibir, Attat, Oma and Dinber). FFW activities observed included ponds, hillside terracing, micro basins (half moon terraces), soil bunds and nurseries. CFW projects visited were road construction sites, drainage canals, VIP latrine and water distribution stand construction. The General Relief and Other Child Feeding programs were studied among a selection of counterparts in Addis: Good Shepherd Family Care Service, Missionaries of Charity AIDS Hospital, Fistula Clinic, Ethiopian Aid and Abebech Gobena Orphanage and School.

The findings that follow are based on document review, on-site observation, interviews with counterparts, technicians, church officials, government officials in Gurage, and participants in all of the programs as well as farmers present on work sites, and exchange of views with CRS/ET and counterpart technical staff who traveled with the evaluators. Time constraints did not permit visiting communities to talk with leaders nor the time to see as many government officials as the team would have preferred. The details can be found in the Appendices which include a description of the methodology used, the travel/work plan, questionnaires applied and checklists consulted at different levels, persons and documents consulted during the visits.

CHAPTER TWO: THE CRS INTERVENTIONS: TECHNICAL AND SOCIO-ECONOMIC ASPECTS

The Maternal Child Health Program

1. *MCH Program Context.*

Most of the MCH programs began as relief operations in the mid-1980s and began their transformation to the present health programs only at the beginning of the 1990s. Since the relief-to-development policy in Ethiopia was announced in 1991 by the new government, the church-based programs supported by CRS/ET have moved very rapidly in fact toward taking a developmental stance (most of the non-church counterparts were already focusing on development). The coordinating agency for the Catholic Church, the Ethiopian Catholic Secretariat (ECS), has a Women in Development (WID) office which has initiated and overseen many workshops to explore opportunities for women, for example in acquiring skills in traditionally male trades, such as welding, metalworks, carpentry. They also disseminated throughout the church network DELTA techniques (participatory processes initiated by Paolo Freire in Brazil); though they had already attempted to make project conception, design etc... participatory, the DELTA method systematized their efforts to identify leaders, empower them with information and follow through to the stage of learning how to be a trainer.

A thorough study was made of CRS/ET's MCH program in late 1992 (*Teller et al, 1993*). Recommendations made in the evaluation included a number of suggested improvements, particularly in the areas of training, targeting and maternal health. CRS/ET took these recommendations seriously and began an intensive program of workshops in which DELTA techniques were introduced and MCH technical content reinforced, and in which new transitional criteria for targeting and graduation were introduced, sometimes against strong resistance. Linkages were made more effective with both church and government medical clinics in support of immunization and prenatal and postnatal care though problem areas remain. In some cases it might have been easier to start up new programs instead of dealing with the residual problems of earlier relief programs in the MCH centers, where dependency mentalities often prevailed. But CRS/ET has for the most part quite startlingly succeeded in a transition to developmental programs that emphasize the technical side both within its own organization (two new MCH professionals were hired in 1993, one in 1995, and another will be added in 1996), in the counterpart organizations (CRS/ET has supported technical health staff in the principal counterpart organizations with strengthening grant funds and monetization proceeds) and in the retraining of MCH staff.

2. *Technical Appropriateness.*

The key questions studied with respect to MCH were: Are the objectives and indicators clear and achievable? Are the inputs or components in place that will change

mother behavior, prevent growth faltering and improve nutritional status? How are the beneficiaries selected? Are the programs reaching the most vulnerable neediest families? Are the rations adequate and appropriate? Is the food used for the smallest child in the home and for the targeted women? What effects of the food can be expected insofar as household food security is concerned? Are the objectives realistic and achievable? How should the program be monitored and evaluated? Are there components in place to make the program sustainable?

a. **Program Objectives.**

CRS/ET objectives for the MCH program have changed over the 1994-96 MYOP period but with consistent themes of moving from nutritional rehabilitation of already malnourished children to prevention of malnutrition before onset (by getting children into the program at an earlier age and by enrolling pregnant mothers), by working toward community-based approaches, assuring closer linkages with health services that can provide immunization for children and pregnant women and maternal care, and coupling the MCH program with sustainable components including income generating activities and loans for small enterprises. More recently, graduation criteria that move children out of the program after an average of two years (instead of the four of five years in the past) contribute to wider coverage and reduced costs per household. The most recent MCH objectives, as cited in the Annual FY 1995 update, are cited as follows:

"1) The incidence of growth faltering among participating children will be reduced by 30% through the provision of health, nutrition and food supplementation interventions within two years"; 2) At least 70% of eligible participating children will be immunized against the six childhood diseases; 3) At least 50% of pregnant mothers will have access to prenatal care, trained traditional birth attendants during childbirth and referral for high risk pregnancies within three year in pilot centers ; 4)) the current health and nutrition information monitoring system will be strengthened; and 5) the technical capacity of counterparts and center staff will be strengthened to enable them to plan and manage the MCH program. A sixth objective, that "the income of 200 women will be increased by 10% through pilot women's credit schemes in 8 selected centers" is treated separately.

Growth Faltering. Inasmuch as there was no baseline survey on growth monitoring incidence, it appears that the objective cited in the 1995 Update may have been misstated and rather intended to be consistent with the recommendation made by Teller *et al* for an objective of "decreased incidence of growth faltering in under twos, with a benchmark indicator of at, or under, 30% incidence each month". Growth faltering is interpreted here to mean the average percent of children each month who have fallen into a lower percentile, i.e., who have not risen to a higher percentile or who

have remained static.¹ During the November-December 1995 evaluation visit, a 10 percent random sampling was taken from four center registers (selected according to available time in the schedule to record the data) to study growth faltering incidence for different months of the year. The data demonstrate an average incidence of growth faltering at 24%. A summary of average growth faltering incidence and the range of incidence for months indicated in the four centers is as follows:

GROWTH FALTERING INCIDENCE IN FOUR CENTERS FOR SELECTED MONTHS OF 1994-1995

Center	Months Studied	Average Incidence of Growth Faltering	Range of Incidence of Growth Faltering
Jellobelina	June through Oct. 1995	19%	12-22%
Alemshet	June thru Nov. 1995	30%	9-64%
Wonji	Dec. 1994 thru March 1995	27%	21-30%
Emdibir	Feb. thru Nov. 1995	21%	13-30%

The growth faltering data were examined for seasonal significance. No clear patterns of seasonal differences emerged. Highest rates of faltering occurred in Jellobelina in September through November while the lowest was in August; in Alemshet where the widest range occurred, there was a 9% incidence in June and October and as high as 64% in September; in Wonji rates were fairly steady, with the highest in February. Emdibir showed a high of 30% in June and a low of 13% in October. Thus, both highest and lowest rates were seen in the month of June for example. There was no clear correlation with months of highest diarrheal (May, September) or malarial (September-October and May-June).

The data for Alemshet were also studied by age group. In this center, the level of growth faltering incidence decreased significantly with age, as follows:

¹ Actual weights, often used to compare previous and current months for the computation of growth faltering, are available on the individual child's growth chart only.

One group of 75 mothers is in attendance at a center on a given day while the rest of those enrolled (about 1500 in each center) come on some 20 other days of the month. Thus more readily accessible data for random sampling is that recorded in Center registers but is shown in percentiles only, which are innately less sensitive indicators to weight changes.

**ILLUSTRATIVE STUDY OF GROWTH FALTERING INCIDENCE BY AGE GROUP
ALEMSHET CENTER**

Age Group	Average Incidence of Growth Faltering
0-12 Months	33%
13-24 Months	25%
25-36 Months	22%
All Ages	30%

These results suggest that an average 30% incidence of growth faltering a month has been a reasonable benchmark. However, the data are from four MCH centers which may not be representative of the 23 now operating. The results by age group from one center are illustrative only. When CRS/ET places its new monitoring system in effect and growth faltering data are collected monthly clearer indications of regional, seasonal and age variations will emerge and permit setting more refined targets to be adjusted in subsequent Annual Program Plans. It is suggested that CRS/ET might, in the interim, include in its FY 1997-2001 DAP a target of reducing annual growth faltering incidence by 20 percent and when in a community-based MCH program for under-twos which assures the presence of the basic components for preventing infant/child growth faltering a target of reducing annual growth faltering incidence by 10 percent each year so that growth faltering at the end of five years will have been cut in half. In addition to food and mother education, there will be an assured clean water supply, increased food availability and access in the targeted communities.

Nutritional Status. Though the maintenance or improvement of nutritional status has not been stated to be an impact objective of the present MCH program in Ethiopia, growth surveillance data are collected in each center and sent monthly to CRS/ET in Addis along with information on mortality and morbidity. Because there was an opportunity to compare the status of children in the program currently with data collected for the 1992 MCH assessment made by Teller *et al*, and because CRS/ET may use anthropometric indicators in future community-based programs, the evaluators thought it useful to make a study in the 10 centers visited. In 1992 Teller found that 84 percent of program children (then under four years of age) were malnourished (<80% weight for age), with 16 percent severely malnourished (<60% weight for age). Our 1995 study of 10 centers (half of the centers, which can be considered representative) from which three months of data were analyzed compares as follows:

Teller et al Study of 1992-93	10-Center Study, December 1995
84% malnourished (<80% WA) under fours	46% malnourished (<80% WA) under threes
16% severely malnourished (<60% WA) under fours	2.3% severely malnourished (<60% WA) under threes

Though the extent of malnutrition has decreased, there continue to be very high rates in some centers, notably 72% in Dakuna and 60% in Emdiber. These may be due partially due to program focus on most vulnerable aged children (70% and 79% of the children respectively are under two) but may also be the result of the protein/vitamin-deficient, *inset*-based diet of Gurage. Cheka MCH, in a deprived rural area, has the highest percentage of under two children --85%-- but lower rates of malnutrition, 53% and less severe malnutrition.

Because the 1995 nutritional status data show significant improvements compared with the 1992 data, a more detailed comparison was made on two centers for which data were available for the same months in 1992 and 1995 and in order to control for the different age composition of children in the centers (<4 in 1992; <3 and mainly <2 in 1995), the 13-24 month age group was broken out for comparison. The results confirmed a drop in malnutrition rates for the same age cohort --the 13-24 month age group-- in which rates of malnutrition had dropped 30-33 percentage points and rates of severe malnutrition for St. Anthony's dropped 5.6 points and less dramatically for Wonji, from 2.8% to 2.1%. The results for months selected are as follows:

Comparison of Two Centers, 1992 and 1995
Rates of all Malnutrition (<80% Weight/Age) and Severe Malnutrition (<60% Weight/Age)

Center	Months Selected for Study	Averaged Degree of Malnutrition/ Age group	1992	1995
St Anthony's	Months of January, March, May, August, October in 1992 and 1995	Severe <60%WA		
		13-24 Months	6.7	1.1
		All Children	6.2	.6
		All Malnourished <80% WA	89	56
			76	49
		13-24 Months		
		All children		

Wonji	Months of February, April, June, September, October in 1992 and 1995	Severe <60% WA		
		13-24 Months	2.8	2.1
		All Children	1.6	1.7
		All Malnourished <80% WA	88	58
		13-24 Months All Children	80	64

Unfortunately, there is no baseline against which to judge these results, to know whether they are attributable to the program or external factors affecting non-program children as well. A control group could be selected in an area of similar socioeconomic status and compared with these results if CRS/ET would like seriously to know that its current program is responsible for these results. A post-control group study of this type lacks the degree of scientific rigor that a start-up control group would have, but it is valuable nevertheless, particularly if CRS/ET opts to take the nutrition-focused approach for MCH and use nutritional status as its indicator

Nutritional Status by Age Group. Results from an illustrative study made for the month of August 1995 for 8 centers show that unlike growth faltering incidence which decreases with age, the average prevalence of malnutrition increases with age but the pattern is not consistent within age groups or centers. The results, which call for further more exhaustive study, are shown below. While the overall averages indicate an increasing trend of malnutrition as groups age, the pattern is consistent for a few centers only such as Wonji, Jellobelina and Cheka, while another center, Meki, shows a reverse trend, and others show rising rates in the 13-24 month group --NACID and St. Anthony's, which then descend in the 25-36 month group. Finally in Alemshet, rates drop in the 13-24 month age group and then rise in the 25-36 month group.

Nutritional Status by Age Group, August 1995, in 7 MCH Centers*

Center	0-12 Months	13-24 Months	25-36 months	Total
WONJI	11%	20%	37%	19%
MEKI	55%	51%	39%	51%
JELLOBELIN A	NONE	36%	44%	41%
ALEMSHET	20%	14%	34%	28%
ST ANTHONY	22%	38%	29%	30%
NACID	21%	42%	38%	36%

CHEKA	38%	54%	67%	50%
Average	28%	36%	41%	36%

*The three other centers studied in detail during November-December 1995 evaluation did not have data available for August 1995--Cheshire, Emdibir and Dakuna.

The nutritional status data studied herein are not sufficiently exhaustive nor conclusive to suggest what CRS/ET country nutritional status targets might be in the next DAP. It is suggested that if CRS/ET plans to use nutritional status impact indicators, they analyze available current data thoroughly by age group in all centers (a consultant could do this in 2-3 weeks) and use it as baseline with informed target-setting. If a program is community-based, anthropometric measurements should be taken at the time of KPC cluster surveys.

Improved Knowledge, Practices and Coverage. Guided by current directions for many NGOs and CRS/Baltimore guidance, CRS/ET is currently planning to continue taking Johns Hopkins child survival KPC surveys and comparing a final KPC with these baseline data. The MCH future model will continue to use food of which larger amounts of CSB have been justified for their nutritional value for children and pregnant women, and the program also has a strong growth monitoring and growth surveillance component all of which argue for measuring nutritional status. On the other hand, CRS/ET has not yet had the chance to focus energies on health education which needs to be refined to the needs identified in the KPC studies. Two baseline KPC surveys have been completed in Cheshire and Nazareth, and new training curricula will be developed in early 1996 with actual training projected to begin later in the year. While guiding criteria for USAID/Washington reviews of DAPs are not yet transparent, there is some indication that nutritional status is the preferred impact indicator for food-assisted MCH type programs. CRS/ET is understandably reluctant to use nutritional status as an indicator while it continues in its current mode of centers which access several communities with a diluted impact on total numbers of malnourished. As they move to community-based models and fully integrated programs (including activities to increase food and clean water supply), they are certain to demonstrate an impact on nutritional status as well as on growth faltering.

Seven major MCH emphasis areas, in addition to the food supplementation and growth monitoring, are the focus for the new-look food-assisted MCH center: a) age targeting--admission of <1 entrants; b) graduates no older than 36 months of age, and as soon as healthy after two years of age; c) close linkage with medical clinic and follow up of malnourished children with rehabilitation feeding; d) child immunization requirement and follow up; e) enrollment of pregnant women including prenatal checkups, tetanus toxoid vaccinations, and maternal care; f) health education for mothers that is not yet based on specific needs of the center identified in the Knowledge, Practice and Coverage (KPC) studies but is increasingly focused on messages and delivered in more participatory settings; and g) economic sustainability programs for women in the program

and, especially for graduate mothers in credit schemes and income-generating activities. The centers visited had all or some of these components or characteristics. They are summarized in the following matrix and discussed in the subsequent paragraphs.

MATRIX FOR KEY MCH COMPONENTS/CRITERIA

Center/Spec. Activities or Features	Age of Enrollment	Age of Graduation	Medical Service Linked	Rehab Feeding-Ch Care	Required Child Immuniz	Pregnant Women Enrolled	KPC Study Status	Credit or Inc Genrtg Activ for Women
CHESHIRE/ Integrated 1995-water points	4M but all <1yr	36 M	<5 out- patients AIDS/FP/ VPharm	NutrReh N=35 3-5 yr daycare	Yes	Anten prom	1st study site	No. But ma- terials prov. For Housing activities. <i>50 members</i>
NACID/Inte gr CBHS 12 outposts	0-8M	24 M + <80 up to 36M	Polycl AN/ FP/ AIDS MCH + 12HPosts		Yes	Anten prom	1st study site	Both credit and Inc-genr.
JELLO- BELINA	4-8M	36 M	HCS Clinic not linked	No Rehab	Yes All at 18 M	No enrolled pregnant.N o places	Program v. Static	Credit. N ²⁰ ; grew to N=40
ALEMSHET	0-8M	36 M	Nearby clinic but not linked	No Rehab	Yes 50%, 12M. All, 24 M	No. Plan add reg. Mothers when again pregnant	Most are >24M	Credit for 80 MCH 20% grads.
ST ANTHONY S	4-8M	36 M	HCS Clinic	Rehab stopped yr ago	Yes All at 18 M	Enrolled 100 P Jul 94 then they→MC H.	A few new ones.	Credit. Wld form lgr gp t open a shop.
MEKI Water source	<8M	24+ Undef	Attached clinic but prov treatment	Weekly NReh	Yes, nearly 100% by 12M	Yes, small but plan increase		Yes.N=13 w Maln childre Also IG but credit pref'd.
WONJI	<8M	24+ <80% in principle	Attached clinic v. active	Yes	Yes. 50% by 12M	Inc from 20 year ago to 116	Dynamic prog	Yes N=70 MCH wome- grads
CHEKA	2-8M	24+ prog phase	Nurse comes 1x wk	Yes but no food	Yes, most by 9M	Inc from 42 year ago to 157	Good prog in difficlt circum	No credit, remote rural area

EMDIBIR	4-8 M	24+ <80% in principle	MOH clinic nearby <i>TBA trained</i>	no	Most by 9 12 months	1993: 150, maintain that no.	New Prog	Yes, N=85 in villages, bega in 1994
DAKUNA	some at 2 M, but most 4- 8 M	24+ <80% in principle	Mission Clinic (Attat branch)	?	75% by 9 months	1993: 150, maintain that number	New Prog	2 groups 80% MCH 20% gr. N=80

Targeting and Graduation. Site selection for MCH programs has actually been geographical targeting to the poorest within counterpart boundaries, and in the majority of cases, has been developed around the infrastructures available and constructed for relief feeding in the 1980s. Coverage data are difficult to collect in centers who are not always familiar with all of the villages from which the women and children come. In Fedis, the team and MCH staff attempted to calculate the extent of coverage. Broad estimates were made of the populations of each village and then local officials gave an idea about how many mothers in each of the villages should be attending (have small children, are poor, etc.). We guessed roughly that the program was reaching under 50% of those in need. Not all centers have a relief distribution past and are new MCH programs, such as those in Nazareth and the centers established in Gurage by the ACS. It has been supposed that without a relief past, the MCH can more readily be perceived as a health unit but it was in Gurage that the team heard the MCH center referred to as a "food distribution site". Beneficiary selection is carried out, often in collaboration with development committees, peasant associations and followed up by house-by-house screening to select the most deserving according to differing but similar criteria favoring poor, large-sized families, female-headed households, and available assets.

An estimated three quarters of CRS/ET's MCH program is now targeted on under twos. CRS/ET has been attempting to target increasingly to younger children. Following the 1992-3 Teller report recommending that the program, then open to children under four years of age, be focused on under twos, new guidelines were issued with the objective of moving in the direction of limiting the program to <24 months old but permitting malnourished children <80% W/A over that age to stay in the program up to 36 months of age. Not all counterparts agreed and still do not agree, and the guidelines issued left the door open for laxer interpretations--e. g., some children over two who are normal (>80% weight for age) could continue in the program up to 36 months. In fact in the 10 MCH centers visited, the two new ones in Gurage--Emdiber and Dakuna--were the only ones that strictly observed the 24 months + <80% WA criteria. Others were progressing toward guideline conformity. It can be noted from the Matrix on Key Targeting Indicators found on the next page that the degree of observation of eligibility/graduation criteria directly affects the dynamics of regular new admissions and the age composition of the center. Haraghe had the most static programs and was keeping children up to 36 months of age. In Jellobelina, no children

under one were in the program and there had been no new entrants for more than a year; 37% of the children were over two years of age and well (80% WA or better). For the centers visited, about 75% were in the targeted 0-2 age group. In 1992 Teller estimated that 6-18% of program children were under one year of age; in 1995 in the 10 centers visited, an average of 26% were under one year old.

Immunization Coverage of Children. Immunization coverage of children is reportedly very good, but there is not an adequate reporting system. Coverage is achieved by effective linkage with nearby government or mission clinics. Most effective was the totally supporting mission clinic in Wonji which besides assuring that all on-site children were vaccinated, sent a nurse to the MCH centers in the area to give immunizations on certain days of the week. To remain in the MCH program, children must be up to date on their vaccinations. Clinics visited reported most children were fully vaccinated by 18 months of age and many by 12 months. Techniques are needed to simplify the checking task in the clinics. Currently, different methods are used. MCH staff may begin the clinic by checking all of the cards of children to be weighed that day, or the cards are checked during the weighing, recording and fee paying steps. Frequently cards were needlessly checked when a clearly marked "FV" for Fully Vaccinated or other indication might be used. Further the recording of the vaccination might be simplified by drawing a red line on the cards when the children reach 12 months to note the number (by quarter perhaps) that are fully vaccinated out of the total and then reporting the total number (percentage) of those they vaccinated by 12 months of age.

KEY TARGETING INDICATORS
MONTHS OF AUGUST, SEPTEMBER, OCTOBER 1995 (OR MOST RECENT
MONTHS FOR WHICH DATA ARE AVAILABLE
FOR 10 CENTERS VISITED BY EVALUATION TEAM 1995

Center	Average % over 3 Mo period who are Severely Maln*	Average % over 3 Mo period who are Moder- ately Maln*	Average % over 3 Mo period who are Normal*	Average % New Entrants over 10Mo period Jan- Oct 1995	Average % of each age group in program a)0-12 b)13-24 c)24-36	Average % in program who are >80% WA + . >24 months of age **
Cheshire	Jul-Aug- Sep last available 1%	44%	55%	NA	Apr-May a) 29% b) 48% c) 23%	Apr-May 12%

NACID	1.5%	38%	61%	Average 52 new per/M Jan-October	a) 28% b) 49% c) 23%	13%
Jellobelina	2.2%	43%	55%	No new entrants (for year at least)	a) 0% b) 15% c) 85%	37%
Alemshet	1.9%	29%	69%	Average 57 new per/M Jan-October	a) 30% b) 27% c) 43%	32%
St Anthony's	1.0%	31%	68%	A few new in last months only	a) 30% b) 25% c) 44%	32%
Meki	2.0%	45%	53%	Average 78 new Jan-October	a) 17% b) 74% c) 9%	5%
Wonji	1.4%	30%	68%	Average 62 new Jan-October	a) 29% b) 36% c) 34%	18%
Cheka	3.5%	50%	47%	Average 83 new Jan-October	a) 40% b) 45% c) 15%	8%
Apr-May-Jn last available Emdibir	4.0%	56%	40%	New not reported	a) 32% b) 47% c) 21%	0
Apr-May-Jn last available Dakuna	4.2%	67%	28%	New not reported	a) 27% b) 43% c) 30%	0
Averages	2.3%	43%	54%		a) 26% b) 41% c) 33%	16%

* <60% weight for age is severely malnourished; >60% and <80% weight for age is moderately malnourished and >80% is normal; **Children above 24 Months and >80% WA are "ineligible" if CRS/ET criteria established in 1993 are strictly interpreted.

Maternal Care. Efforts to include pregnant women and maternal care in the MCH programs are still fledgling, but highly laudatory, given worldwide inadequate attention to this omission. Progress has been made with respect to enrolling pregnant women and following their care through childbirth. However, center staff are uncertain about allocating spaces for pregnant women out of their total 3000. In the past, this has normally meant 1500 children and their mothers so a decision may be needed to suggest how pregnant women should be accommodated and the number that would be fair. Once pregnant women are enrolled, the centers keep them on with their new babies. The centers require that the pregnant women had their tetanus toxoid and a minimum number of antenatal visits. Like the child immunization program, maternal care depends on adjacent clinics and program quality depends on effective linkage. Enforcing these links was one of the central recommendations made by Teller *et al* in 1992 and CRS/ET and counterparts for the most part have succeeded in cooperating with government clinics or ensured medical support services with mission clinics. Highly successful are NACID, Cheshire and Wonji, while Gurage as a new program has reserved 150 places for pregnant women. Meki and Hararghe need attention most with respect to improving relations with the Health Ministry and/or reviving potential support from mission clinics. The policy for enrolling pregnant women in the MCH program was unclear in the three clinics visited in Hararghe. At the moment, it is difficult to recommend the "correct number" of pregnant women that should be enrolled per center and the best solution would seem to be to have some regional workshops to take up the question and obtain part of the answer from the MCH staff and committees of the peasant associations.

Health Education. Since the Teller evaluation of 1992 which was highly critical of the education component, many improvements have been made in focusing messages and presentation techniques, but there is still need to gain the support and participation of mothers in the solutions to nutrition and health problems. MCH coordinators for each area are a part of the counterpart technical team and the educators show an awareness of DELTA techniques --sitting among the women while giving health lectures and making them of short duration, with a limited number of seasonal messages. However, there was more of a tendency to obtain participation in the form of repeating the content of lessons given, rather than more challenging requests for ways of dealing with problems with the means available. Little attention was given to the nutritional qualities of CSB and the need to reserve it for small children and pregnant women. CRS/ET is aware of the need for training and reinforcement of past training for its counterpart staff and plans to introduce a new curriculum based on the KPCs administered in Cheshire and NACID centers starting with trials in late 1996 and generalized application in early 1997.

Food Rations. The foods provided --5 kilograms of wheat, 6 of corn-soya-blend (CSB) and 3 liters of oil-- are intended for mother and child but in fact they continue to be widely shared, though CSB often lasts more than half the month and is sometimes and to a degree, reserved for the targeted program child and other small children in the home. CRS/ET, noting the high levels of malnutrition found by Teller *et al* in 1992, increased the CSB by one kilogram a month, but perhaps missed an opportunity by not introducing the addition as *strictly for weanlings* whose progress should be apparent.

Though center staff and mothers refer to CSB as *fafa*, a soy fortified food supplement based on wheat or sorghum, and thought of it primarily as a special children's food, they said they mixed it with other staple grains for family dishes. If present rations were reserved for the targeted mother and child, the food would meet their basic needs for 14 days; when shared within an average family of six, it would meet basic needs for five days of the month.² These estimations coincide with the answers given to the question asked of MCH staff and mothers: "How long did the food given by CRS last during the previous month?" Most often mothers said that when only children were given the food (rarely and only in families of four) the food lasted two weeks. At the other extreme, in large numbers of 7-8 eating from the family pot, the food lasted 2-4 days. CRS/ET and counterparts should take up the entire question of rations with MCH staff and mothers and decide what the appropriate nutritional rations destined for the smallest child plus any opportunity costs for the mothers' time should be in the new programs. The answer also depends on CRS/ET objectives for the MCH program: can the objectives be purely improved nutritional status and health of under twos and pregnant women? or is an income transfer for poorest and neediest *families* also in the formula? To attain the former objective, it might be more effective to provide more CSB and a small amount of oil,³ but an arbitrary decision should be avoided.

3. *Socio-Economic Aspects*

Key questions in the scope of work and identified by the evaluation team are: How do counterparts and beneficiaries perceive and administer the program? Do participants take part in its design, redesign and other aspects? Does the program

²According to AID's Commodity Reference Guide, the number of calories and proteins per 100 grams is as follows:

Wheat		330 cals	12.3 protein grams
CSB	358	13.8	
Oil	884	-	

Therefore, the ration yields:

5 Kg Wheat	16,500	615
6 Kg CSB	21,480	828
3 liters oil	26,520	-
Total	64,500 cals	

Per day it can be estimated the mother/child pair require a minimum of 4700 calories daily.

Based on average caloric requirement of 2300 per person, the food would provide a family of 6 sufficient calories for 5 days. If reserved for the mother and child, it would meet their full needs for 14 days. It is of course intended only as a *supplement* to household food, but few use it in that manner since it runs out quite early in the month depending on family size.

³At least one food-assisted child survival program e.g., distributes 10 kilos of CSB and 1 liter of oil for mother/child pairs.

promote dependency? What are the relations with government health officials and other NGOs?

Most of the recommendations made by Teller *et al* were followed up with one exception: that there was need for studies to increase cultural understanding and respect for existing community and family belief and value systems. In the same vein, the 1992 team suggested that biomedical and religious agendas should not be imposed over benign traditional beliefs and practices. While it is recognized that it is not easy to coordinate and work closely with the associations and committees of the multiple communities now attending MCH centers, greater effort is required to stimulate a more dynamic participation of women in the centers and to create a sense of ownership. Finding out more with respect to how families perceive and deal with common illnesses is particularly important at this juncture before new health education curricula are formulated. Though KPC surveys are being made to determine current health knowledge and practices, additional anthropological studies are needed. In-depth participation from mothers is essential to learn why certain practices prevail, which behavior should be validated or reinforced, and how common harmful practices can be modified most effectively. It has earlier been suggested that rations be discussed in such a process and mothers take part in helping to decide what they should be (within a set of options presented). Further, there is need for orientation and reorientation of MCH and counterpart staffs that MCH is a health program targeted to vulnerable family members; one counterpart referred to the MCH clinic day as a "food distribution". In areas like Wonji, because of visits made by the mission clinic nurse to the community, there was greater sensitivity with respect to local needs and practices, while in another area, no one could name a single home remedy for diarrheal treatment. Also noted earlier in the clinics visited were improved techniques for delivering education lessons apparently the result of DELTA training.

4. *Integration and Food Security Context.*

To what extent are the programs integrated or planned to be integrated? How do the programs fit the food security context? From earlier isolated "MCH food distribution centers," the programs are evolving into partially integrated status. An example is Fedis in Hararghe. Fifty percent of the families whose children and mothers come to the MCH center live in three FFW or CFW catchment areas in which conservation activities are carried out --checkdams, terracing, irrigation, bunding. NACID and Cheshire are prime examples of integrated programs with water, soil rehabilitation and health services and poverty lending combined. The most directly related development activity to effective health services is the supply of clean water. In Meki, for example, water is provided for the MCH and the community, but in neighboring rural Cheka, there is not yet access to clean water. Severe malnutrition is nearly 5% in Cheka compared with 2.4% in Meki (October 1995). Counterparts, however, have not only accepted but have on the drawing board concentrated, focused programs for the future, confined to limited geographical areas where health activities will be complemented not only with the closely related credit programs and clean water supply but also by programs to increase food availability.

MCH programs answer food security objectives in two ways: a) increased utilization of food consumption by reducing diarrheal and other infectious diseases and deparasitisation which result in lower absorption losses; and b) increased household food consumption of vulnerable members and of the family through the food supplements given in the health centers.

THE WOMEN'S CREDIT PROGRAM

The key questions the team attempted to answer were: Were the objectives achieved nationally? How were the programs perceived in the MCHs and credit association groups visited? Is the program acceptable and/or culturally feasible? What are the loans being used for? What is the income being used for? How are beneficiaries selected? What do women (and men) think of the program?

The credit program is young in Ethiopia. Not yet formulated at the time the 1994-1996 MYOP was written, it was presented in the 1995 Annual Update. Its quantitative activity target was that "the income of 200 women will be increased by 10 percent through pilot women's credit schemes in 8 selected centers in FY 1995". Programs were started with four counterparts in different areas: the ACS in Emdibir and Dakuna; the HCS in Alemshet, Harar, Jellobelina and Fedis; NACID in Nazareth; and Wonji. After the launching and success of these initial programs with participation of 646 women, training and promotion was begun in June 1995 in other areas: Cheshire MCH, Metehara MCH, Meki and IHA/Addis from which an additional 210 women were taking part by September 1995. By that date, in the four initial areas -- ACS, HCS, NACID and Wonji-- 426 loans had been taken with a total birr value of 77, 158 or an average loan size of 181 birr (\$29). For all of the sites, by September 1995, a total of 846 women were putting aside savings which averaged 36 birr a person (\$5.70). Nearly 100% had repaid their loans on time with no defaults. (Source: CRS/ET) While the net income has not yet been monitored, it can be speculated that the 10% targeted increase in the first four sites was met by the end of FY 1995.

The strongest feature of this program is its cultural appropriateness. Saving is not new to Ethiopian rural women, as they have all participated in putting aside sums through their women's organizations, for offsetting costs of funerals. Women also have taken small loans before, but at higher interest rates (which we are told can carry very high interest rates). The typical pattern is for the woman to take a small loan of 100-200 birr, and net only 20-50 from this either in immediate resale of animals or vegetables, or fattening and then selling animals with the higher profit for the three months investment of time. Some of the activities are more time-consuming than others--petty trade takes more time, while cattle-fattening does not. Women reported that men, after some initial hesitation, are all for these activities and assist with such functions as oxen sale. The second and third loans become larger and the volume and diversity of their activities grows, with also larger income. When asked how they used the profits, women said they used the money for improving their homes, they paid school fees and bought children clothes. Rarely did they offer information about food purchase, but when probed, they said they ate meat more frequently and enjoyed a larger variety of foods than they did before they had their business. One group expressed the

dream of joining together 20 members for a larger loan to buy a pump to irrigate a tract of land and grow food.

The program is partially financed with mothers' fees and is run through the MCH center (the "contact persons" of the MCH or specially assigned credit women as in Meki) who are responsible for recruiting mother groups and for their training. Priority is given to those meeting the following criteria: poverty (monthly income <50 birr); female-headed households; >5 in the family; reputation in the community; current or former MCH participant; interest and willingness to take part in group loan scheme and to participate in women's organization activities and meetings; and feasible proposed reasons for loan.

During field visits, it was observed that the program of course favored MCH women but planned to open it to other community members in the future (or was already doing so, as in Wonji, Alemshet and Dakuna). In Meki, the 13 selected were mothers of severely malnourished children. Other centers preferred to start with women groups from the closest areas. Others said that graduating women were the most important candidates because they would need to have something now that they were no longer eligible for the food. It will be of great interest to follow these graduate mothers who take loans to see how their new children fare--whether she buys food for them. In Meki, counterparts said that the women were much happier with the new credit scheme than with the many income generating sewing and other activities they had tried to help them with. "It's their own," said a sister.

FOOD FOR WORK AND CASH FOR WORK PROGRAMS.

1. Objectives:

CRS/ET's Food for Work goal was "to improve the long-term food security of the target areas, through soil conservation and forestry development, and thereby reduce long-term resettlement tendencies by beginning to improve the carrying capacity of the land." The objectives were stated to be "a) to increase the availability of wood for fuel and construction in participating communities through environmental stabilization activities; b) to construct soil conservation structures to control erosion; c) to increase availability of water to rural communities for domestic consumption, livestock and small-scale irrigation; and d) to improve rural infrastructures in the target geographical areas of West and South Shewa."

The Cash for Work goal was "to promote environmental sanitation and water resources development in rural and urban areas in order to assist the target population in improving their health." The objectives were stated to be "a) to improve the sanitary situation in urban and rural areas and thereby promote hygiene, prevent disease and use garbage to produce organic fertilizers; b) to promote water resource development in rural and urban areas; c) to promote soil conservation and reforestation in the rural areas; and d) to promote agricultural development in targeted communities." (Source: Project Document April 22, 1994.)

2. Area-Specific Background and Observations

Nazareth Children's Center and Integrated Community Development. NACID is an indigenous organization which was established in 1989 with the purpose of assisting orphans, war victims and displaced people who came from the northern part of Ethiopia. Though the region itself has not been a drought-stricken or chronically food-deficit area, the effects of war resulted in special pressures on land already suffering from serious degradation and deforestation. In 1991, NACID made a needs assessment to determine the priority problems of 16 peasant associations in the Woredas of Adama, Bosset and Lubo. The assessment identified 15,000 needy and food-deficit people without income from traditional sources such as sheep and goats, and whose land holdings were too small to permit the production of enough food grains to sustain them year-round. The study noted the major cause of low productivity to be soil depletion and deforestation.

Through participatory processes with the community, NACID set up priorities for key activities to be undertaken: improvement of health prevention and access to community-based health services; soil and water conservation and afforestation programs. With the assistance of CRS/ET, it was planned that food aid would help to implement the health and environmental development programs through rations for mothers and children, pregnant women attending MCH center, and for food-for-work programs for the rural community and cash-for-work for urban centers. The activity targets for NACID's Food for Work programs showed the following performance during FY 1995:

Food for Work FY 1995: Source: NACID Annual Reports

Activity	Unit	Targets	Achievements	Percent of Achievement
Fana Juu	Kilometer	188	46.9	25
Soil Bund	"	50	5.3	11
Hillside Terracing	"	100	59.5	59
Cut of drains	"	10	6.8	68
Check Dams	"	10	9.3	93
Ponds	Number	4	3	75
Seedlings-Prod	Number 000s	300	292	91
Seedlings-Plant	" "	100	52	52
Seedlings-Distr	" "	200,000	240,000	120

To accomplish the above activities, 199.6 metric tons of grain and 7 tons of oil were distributed to farmers. The food was sufficient for about 60,000 man days. The number of participants were 967 who worked an average of 69 days. If the participants worked 69 days in a year, the number could be estimated at 1200 affected households.

The team visited Kusai, a FFW site for pond and bund construction 20 kilometers outside Nazareth. The program has been under way for one year only and it is too early to evaluate the change brought about in the environment and future land productivity. Obviously bund construction and tree planting alone do not produce benefits in the short term, but the activities do change farmers' practices--e.g., they would now include such conservation measures along with ploughing their fields. Further, the conservation measures enhance the use of different inputs such as fertilizers for a better crop production. Bund construction reduces soil erosion by controlling water runoff capable of causing damage to cultivated land. The team observed that the quality of the bunds was below Ministry of Agriculture norms--did not meet the specifications for 60 cm of height for the built-up side and one meter width at the bottom of the bund. The bund was somewhat irregular and besides being less than half the recommended height was not compacted sufficiently. NACID explained that it was an early part of the FFW work and that it had improved over time. The closely set ridge and tie approach of bund construction used could cause an overflow of the accumulated water and cause damage on farmland.

To construct a pond with a radius of 20 meters and a depth of 3 meters, the mandays required, according to the work norms set by CRS/ET consistent with Ministry of Agriculture are 6700 (150 people x 45 days) Assuming the daily food "payment" to be worth about 6 birr, the cost would be about \$6500.

Participants in the FFW project said that the PL480 foods, grain and oil, were supplied regularly on a monthly basis. They said that this improved the living conditions of poor farmers and that the amounts provided in no way made them dependent on the program. It was estimated that, though provided sporadically, the food given lasted several days to two weeks in the house depending on the degree to which other foods were available and mixed with the donated foods.

Despite the advantages of NACID working closely with the line ministries in their projects, they need to have well trained technical staff and animators and control standards with regular supervision especially at the initiation of new activities.

The Cash for Work program was designed to alleviate urban unemployment by improving the water supply and sanitation facilities in Nazareth. In 1995 the following improvements were completed in the mandays indicated:

Urban Improvement	Beneficiaries Direct/Indirect	Total Birr Cost
A deep well with a water production capacity of 10 liters per second	4225 households who benefit from the well	525,000 Birr
34 VIP Latrines	60 workers 203 households that benefit from the latrines	245,055 Birr
8 water points	740 households that benefit from the water points	35,060 Birr
650 meters of drainage canals	83 workers 2000 residents who benefit from the canal	38,460 birr

The above sites were visited and found to be in an extremely poor area of Nazareth.

Hararghe Catholic Secretariat (HCS). The four major *woredas* visited by the team were Gurgura in Dire Dawa Administrative Region and Fedis, Kombolcha and Jarso in Eastern Hararghe Zone of the Oromia Region. FFW soil and water conservation, forestry and water development activities are carried on in areas referred to as "watersheds". In fact the sites are arbitrarily selected and do not comprise a major watershed nor are they clearly delineated areas. These community "watersheds" are named after a river basin into which water drains.

Soil and Water Conservation. The major activities carried out within these sub-

watersheds are: a) soil bunds and Fanya Juus on cropland; b) micro basins (half moon-shaped structures), gully control and stone check dams on marginal land; and c) hillside terracing, graded canals and reforestation on hills and erosion hazard areas. The activities protect farm land from erosion by stabilizing the soil. And in areas like Dire Dawa and Fedis which experience erratic rainfall and water shortage, they increase productivity by harvesting rain water between constructed soil bunds and increasing moisture retention.

Afforestation development practices include: a) planting hillside terraces; b) in the micro basins, gully rehabilitation and backyard plantation by individual farmers who have obtained tree seedlings from the four HCS nurseries. The nurseries have produced over 620,000 seedlings of which 540,000 transplantable ones have been planted on communal land or distributed to individual farmers.

Water conservation activities include 6 ponds and 3 spring points.

To accomplish the above programs in Hararghe, a total of 633 metric tons of grain and 25 tons of oil were distributed to farmers/workers estimated at 5300 (40 days of work each, or a total of 211,000 mandays). The foods contribute to household food security though essentially of longer term impact, and also have short-term benefits such as construction of ponds and spring development for human and livestock water consumption. The different grass species established on bunds and forage trees could be used as supplementary feed for livestock.

Cash for Work programs are smaller in scale. Their objective is the rehabilitation of ex-soldiers through environmental sanitation, land preparation and road construction and has the following achievement for FY 1995

Activity	Achievement	Total person days	Cash delivered in birr
Road Construction	27.39 km	54,780	328,680
Road Maintenance	12.7 km	6,360	38,160
Land Preparation	22 hectares	4,268	25,608
VIP latrines	10	1,440	8,640
Weeding	22 hectares	1,100	6,600
Total		67,948	407,680 Birr

The number of beneficiaries in these projects was 1,228 ex-soldiers who were given an opportunity to become integrated back into farming. The degree of success is unclear.

Gurage , Archdiocesan Catholic Secretariat (ACS) . ACS began operations in Gurage with CRS support in 1993. Like most of the southern Ethiopian zones, the area is densely populated. Serious environmental degradation is seen in huge gully formations

and eroded soils, often the result of over-grazing, deforestation and encroachment of marginal lands. Most farmers are at subsistence level and depend upon *inset* or false banana as their staple food. Inset is essentially a carbohydrate food with low protein content and therefore dangerous lacking in the necessary nutrients for an adequate diet.

ACS' FFW programs had the major goal of alleviating food deficits by developing environmental infrastructure and water sources and by disseminating crop diversification. The achievements of the last three years include:

- ▶ the establishment of four nurseries with a capacity of producing 2 million seedlings a year;
 - ▶ the production of 4.2 million seedlings, 80% of which have been distributed to farmers and 20% planted on denuded land and communal sites;
 - ▶ the plantation of grasses over 1097 kilometers;
 - ▶ the construction of Fana Juu and soil bunds over 55.2 kilometers;
 - ▶ the building of brushwood dams over 249 kilometers of gullies;
 - ▶ the construction of 56 kilometers of feeder roads and the maintenance of 66 kilometers of roads;
 - ▶ the construction of 15 small bridges.
- (Source: ACS Emdiber Report)

During 1995 alone, 773 metric tons of grain and 56 tons of oil were delivered to farmers participating in the activities. 28,489 farmers from 35 peasant associations benefited. Participants were selected by the communities according to need and low incomes. Participants work 17 consecutive days and receive 50 kilograms of wheat and oil and are then replaced by other groups.

The first of randomly selected visits was to a soil and water conservation and gully treatment site a few kilometers southwest of Emdiber. Known as "the Emdiber gully protection site" it is at 1900 meters of altitude. Workers constructed brushwood check dams and established grass sodding at about two meter intervals; and between the grass strips along the contours between bunds, they planted different types of seedlings including *Acacia decurcane*, *Acacia saligna*, and eucalyptus along the slopes of the gully. The grass sodding covered 20 kilometers and brushwood check dams covered 5 kilometers over 5 hectares of land plus adjacent gullies. Workers had planted the seedlings in 1994-95. The checkdams made of wooden brush were rotted and decomposed. Project leaders had chosen the type of gully protection --wood brush dams and sodding with grass-- because they were the only materials available locally (no stone e.g. was available) for this purpose. So while wood brush appears inappropriate --it can be destroyed in a short time and might contribute to deforestation-- it is the only option and does last through two rainy seasons after which a vegetative cover might have grown on the accumulated soil. This type of gully protection could tolerate erosion if protected from external use. There is the further point to be made in its favor, that only brush and branches of trees are used and would not require tree felling. To be effective in protecting deep and actively growing gullies, though, additional work needs to be done, including diverting running water in the gully, "closing" or protecting the area from

animal or human intrusion and rehabilitating the soil by planting different types of grasses, legumes and tree species such as acacias, tree lucern, lacunae, and rides, bamboos, sisal and erythron that are readily established. A further site visit on the road to Arekit was one of Fanya Juu construction and gully treatment similar to that described above which had been completed according to standard norms. Farmers understood and accepted these practices.

The other important projects visited were the horticultural demonstrations at Oma, Attat, and Dinber which were among the 15 targeted food for work areas scattered over 35 peasant associations within districts affected by food deficit and in need of rehabilitation. With the objective of improving food security and diet variety by introducing crop diversity, the ACS agricultural staff have set up demonstration farms to reach farmers through 18 animators, 8 target groups, 64 contact farmers and 1280 fellow farmers. The method is that of multiplier effect, one commonly used in agricultural extension programs. The demonstration farm at Attat showed a highly complex range of plantings including:

- ▶ Vegetables: carrots, beet root, cabbage, onions, peppers and tomatoes;
- ▶ Root crops: sweet potatoes, cassava, taro and Irish potatoes;
- ▶ Cereal and legume crops: wheat, barley, teff, field peas, beans and groundnuts;
- ▶ Fruit trees: oranges, bananas and avocados;
- ▶ Forage: vetch, oats, rhodes grass, panicum grass and alfalfa;
- ▶ and seedlings for afforestation: acacia, sesbania, eucalyptus.

This variety makes Attat the most advanced research and adaptation trial station. However, it is felt that the objective of reducing nutritional deficiencies caused by dependency on *inset* could more effectively be attained by concentrating on carefully selected high-yielding varieties of crops, notably, wheat, barley, Irish potato and pulses for the high altitude areas above 2000 meters; and sweet potato, Irish potato on the areas below 200 meters. The Gurage people traditionally plant 50% of their holding in *inset*, *chat*, and coffee, reserve 25% for cattle grazing, and put the remaining land into cereal or other crop production. Because land holdings are small --about 0.6 hectares per household, the farmers have had to employ intensive agricultural methods. It is thought that changing these intensive farming practices by introducing cereal crops which have lower yields per hectare will go against farmers' wisdom and even negatively affect nutritional availabilities. Thus, the complex demonstrations, while valuable to research, seem not to be the most appropriate. Rather, promoting the cereal seeds and tubers that have already been identified and selected by the Institute for Agricultural Research (IAR) through a full-scale seed multiplication centers would seem more desirable for acceptability and early impact. With an assured supply of seeds, the demand could be stepped up over the present contact farmer system with the provision of credit and the support of radio, audiovisuals and films. Such promotion in the present setting risks putting demand ahead of seed supply.

3. Technical Appropriateness.

The key questions were: Were the FFW/CFW projects selected the best ones based on technical criteria of land needs? Were the expected end results (assets) as important as providing food for the unemployed or poor? Were they implemented properly? (Have the targets been achieved? And MOA-prescribed specifications observed?) Were the sites chosen well? Were the beneficiaries the appropriate ones? Were the payments in either food or cash the right ones for the situation? Were the work norms established by the MOA reasonable? Are the ration rates the best ones? Were the project examples ones that can be replicated by farmers? Are they sustainable projects? (counterparts and farmers will continue to keep going after the end of the project)?

To what extent has the project objective --to promote food security and improve the livelihood of the targeted rural community-- been achieved? During 1995, an estimated 54,000 poor and unemployed workers from 65 peasant associations in the ACS, HCS and NACID project areas received food amounting to a total of 1605.9 metric tons of grain and 62 tons of oil. Indirect or long-term benefits are: a) reduction in the rate of soil erosion; b) increase in soil moisture; c) improved access to water; and d) reforested areas.

The sites were correctly selected according to criteria of food deficiency, lack of potable water supply; and characterized by heavy soil degradation. Beneficiaries were chosen by the selection committees of the peasant associations and from all information available, were fairly chosen. It is believed that providing food for the workers contributed to productivity and nutritional health of the family and was appropriate, given the food insecurity and deficit in the area.

In the sites visited by the evaluation team, it was obvious that a large amount of time and labor had gone into the rehabilitation of hillsides and of denuded lands, although the effect of this work is not conclusive at this point. There were terracing errors in micro basin construction, which did not conform to standards. The specifications are a height of 20 centimeters and a half moon shape, properly lined up for water harvesting which will permit moisture retention and seedling survival.

Seed bed preparation and plastic tube filling is well under way in the nursery of Eja Aneni (Dire Dawa) which will be ready for the coming small rainy season plantation (February, March and April). In the nursery, seedlings of vetiveria zizanoides, panicum and rhodes grass are also ready to be transplanted. The nursery that was established in 1995 has produced about 97,000 seedlings of different types and were distributed to the farmers in the project area and some were planted on the communal land where micro-basins and hillside terraces were constructed.

Efforts made to stabilize soil bunds and agroforestry by growing different grass and legume species such as alfalfa, vetiveria lablab, Rhodes grass and sespania forage trees are promising because of their multi-purpose nature (and therefore short-term benefits).

Raised soil bund construction for water harvesting in Dire Dawa and Fedis areas have had greater impact on crop stands and are anticipated to result in better yields than those areas without soil bund construction because of higher moisture retention.

Water development projects, such as pond construction and spring development have greatly helped farmers who otherwise would have walked several kilometers in search of water. The water projects have served household needs, livestock and small scale irrigation.

The Cash for Work provided both direct (payment in cash) and indirect (improved infrastructures and environmental sanitation and land preparation for ex-soldiers) benefits. It is thought that the Food for Work and Cash for Work programs were the most appropriate approach in helping to improve the nutritional status of the needy and food deficit rural areas and the rehabilitation of the displaced and ex-soldiers in urban communities. The programs provide short term benefits to the food-insecure of the community and long term benefits in the rehabilitation of natural resources and environmental protection.

Some of the work norms may require revision now that more experience is available with the different kinds of bunding and conservation techniques, and the assessment work already started by the CRS/ET agricultural team should be continued and discussed with MOA technical staff.

The Food for Work activities--soil bunds, water development, and afforestation--are ones that affect the daily life of the farmer and they are fully understandable to him in terms of improving his agricultural output. However, more careful assessment of the farming community needs, through participatory planning, would further strengthen the activities.

4. Socio-economic Aspects.

To what extent did FFW/CFW beneficiaries participate in the projects, in identifying problems, in setting out priorities, in planning, implementation, management, and monitoring/evaluation? What were the attitudes of beneficiaries towards the programs? Did the programs affect farmers' own production or did they have an adverse effect on local markets? Is the institutional capacity of counterparts adequate to administer the programs and the assets created? Are the beneficiaries prepared to protect the assets? What have been the working relations of CRS with counterparts, with agricultural and natural resources ministries and other NGOs working on similar projects in the area? What have been the working relations of counterparts with the agriculture ministry at district and zone levels? With other NGOs in the area?

Counterparts have repeatedly stated that FFW and CFW beneficiaries participated in project selection, identification of problems, setting out priorities, in planning and implementation but it seems unlikely that the beneficiaries identified very much with the programs given the size of the project area. It was rather a mass

mobilization activity. Nevertheless, beneficiaries had a positive attitude toward the program though the long term benefits are not yet known.

According to counterparts, relationships with line ministries have been smooth and have consisted mainly of an exchange of information on both technical and administrative levels. In Gurage, the team visited the zonal MOA officer in Wolkitte who is in charge of all Agriculture activities. It was clear that the Zonal MOA had the mandate to check on technical aspects of NGO projects but that doing so was still impossible due to staff constraints. He confirmed that very good working relations existed and said that the ACS plans for the six-area Integrated Development Project had been thoroughly discussed and approved by the zonal officers.

5. Program Integration and Food Security.

To what extent have past FFW/CFW programs been integrated and fit into food security concepts? What about changes occurring in the programs and the ones being planned? Are there changes occurring that give more importance to the assets than the food or cash relief provided? In what sense is the program integrated with that of USAID and other NGOs?

Past Food for Work programs were set up to meet needs in relief areas where food was delivered to the victims of drought with the primary goal of helping the beneficiaries. In keeping with the government mandate to stop giving food, relief food for work was developed and then developed increasingly into development programs. Present planning calls for concentrated, integrated programs that continue conservation efforts, but which add inputs (fertilizers, improved seeds, irrigation) that will increase yields and permit shorter term benefits and impact. The farmers are aware that the food aid support from FFW and CFW is a short term benefit and will end one day.

OTHER CHILD FEEDING AND GENERAL RELIEF

Other Child Feeding (OCF). The FY 1995 Annual Program Update states that the objective of OCF is "39 humanitarian institutions helping 10,500 orphans and other needy children ...with food commodities" and the monitoring indicators are providing 882 tons of food commodities for the 10,500 children." The design for multiple and highly diversified programs under the OCF rubric has been given very short shrift in the CRS/ET portfolio. Perhaps because the OCF category covers such a wide range of projects, from those that are essentially welfare cases to highly integrated development programs or health programs for mothers and children, providing an adequate design has been elusive.

During field visits, the team saw well formulated income-generating activities which train or educate participants so that they meet developmental criteria. No expectations have been laid out for these projects and they therefore appear to be passive institutions into which resources are poured without changes in behavior or well-being of the beneficiary population, the criterion for project impact. In fact, though the institutions are stationary by nature, many of the beneficiaries are highly transitory, remaining for limited intervals and departing as changed, often self-supporting or self-reliant which they were not upon entering. Other beneficiaries *are* long-term and unlikely to undergo positive change such as terminal, elderly patients. Two of the outstanding examples of institutions which transform their clients are the Good Shepherd Family Care Services and Abebech Gobena Orphanage and School, which the team visited. Good Shepherd, like several other CRS program sponsors, assists some 700 destitute women and their children in Addis' *kebeles* 8 and 9 in *woreda* 13. The women are given training and seed money which is replenished through a revolving fund. They work at vegetable gardens and make *injera* the local bread for sale, or they work in flour mills, sewing, tailoring, knitting and woodworking. When their earnings reach 250 birr a month, women no longer receive food and, as mentioned, they repay the seed capital. 300 children (100 residents and 200 non-residents) are followed in the clinic with growth monitoring and severely malnourished children are fed four times a day. Home visits recruit malnourished children. Latrine construction, cleanup campaigns, road and drainage system construction and water stands complete this integrated urban community project. The Abebech Gobena institution is essentially an orphanage but has also served as an adoption site, and its children are educated and trained in skills that will make them self-supporting: cottage handicrafts including sewing, embroidery, weaving, carpet and sweater making, food processing, grinding mill service, public shower services, and farming activities.

The team was in agreement with recommendations formulated in a more in-depth study made recently by Cekan and Payton in which it was proposed to treat the programs that so merited to be developmental institutions with graduating participants. CRS/ET technical staff need to separate those programs that help or transform participants from the programs that assist chronically needy who are unlikely to be changed or become independent. Impact indicators need to be developed such as: percent of participants who graduate each year who are now self-supporting. For the

health programs, progress in changing nutritional status, health education etc. should be monitored to fit MCH guidelines.

General Relief. A very considerable amount of food over the FY 1994-96 MYOP was programmed for general relief, over 40 percent for 146,000 beneficiaries representing about 20 percent of the total beneficiaries programmed. Two thirds of these programs are carried out by Mother Theresa's Missionaries of Charity (MOC). Ethiopian institutions that take care of disabled, elderly, and terminally ill depend heavily on CRS/ET and other donor assistance and would suffer severely were the programs to be terminated. However, there is a need for such institutions to find opportunities for survival and to broaden their donor bases.

Beyond food support to the institutions, the case has already been made elsewhere for strengthening the NGOs who care for these disadvantaged in the country that can help Ethiopia to achieve a healthier civil society (Cekan proposal), an area that the evaluators could not review in detail but believe worthy of further feasibility study.

CHAPTER THREE: CONCLUSIONS AND RECOMMENDATIONS

MATERNAL CHILD HEALTH

CONCLUSIONS

1. Growth monitoring and surveillance continue to be carried out very well by MCH staff as they were when Teller *et al* reported in 1992. Impressive are the graphs showing the nutritional status of children and other MCH achievements. The growth surveillance (GS) data compiled for CRS/ET is not being exploited partly because of uncertainty about which monitoring and evaluation (M&E) indicators CRS/ET will select (question that is to be decided with CRS/Baltimore assistance in early 1996). Current reporting fails to reflect the excellent work being carried out as discussed further on with respect to keeping child immunizations. Though monthly reports failed to reach the counterpart or CRS/ET for 5 months (from ACS centers), this brought no response from the counterpart or CRS/ET. Monthly summary nutritional status reports showing no new children entering for over a year, as in Jellobelina, should signal stagnancy and entail a visit with the counterpart and the center to see why. ACS centers remain confused about the percentiles that should indicate severe malnutrition and are using outdated forms. Thus the centers get little or no feedback on their reporting, positive or negative.

Good new reporting forms are in draft in CRS/ET which will record both nutritional status, growth faltering and record immunizations, antenatal visits, and other data.

RECOMMENDATIONS

1. Recommendations are made throughout this report on this central MCH weakness: lack of an adequate reporting system and feedback. Though the question of which format and indicators should be used remains unresolved, an interim means of ensuring communication with the center is vital. Regular feedback is needed by MCH staffs so that they can understand and be motivated by, the positive results they are achieving or learn what they are doing wrong. They make graphs showing monthly rates of malnutrition but need to know how rates in their center relate to those in other centers. Every quarter, CRS/ET should send a semi-form letter noting with congratulations or concern, what has transpired and asking if they need assistance. In the case of high rates of malnutrition or incidence of growth faltering, little or no movement within the program--no new entrants or children under one year, CRS/ET should make a visit together with counterpart technical staff; or, minimally, request that the counterpart look into the situation.

The ACS centers urgently require up-to-date forms with clear percentiles of severe malnutrition. Their excellent work in preparing graphs should be applauded but the changes should be made and they should be cognizant of what the normal range of severe malnutrition is in the rest of the program.

<p>2. Where the MCHs have been functioning for many years, counselling and health education techniques have improved since the last evaluation, undoubtedly due to the intervening training and motivation activities and the hiring of MCH coordinators. Health education messages are focused and delivered in simple messages, but they give more attention to desired actions than to how they might be achieved, and they fail to involve the mothers sufficiently. Though animators make home visits, there is the impression that there may not have been sufficient structured efforts to find out from the mothers what they can change and what they are already doing right. Understanding local cultures are not always encouraged by counterparts, who may see local practices as innately harmful because they do not respect commonly accepted medical procedures. When asked about what mothers do that is okay in the event of diarrhea, the answer was "they do many harmful things" but no one knew about the many harmless preparations given to children with diarrhea.</p>	<p>2. Communications with mothers would be greatly facilitated by a) greater sensitivity of MCH staff and counterparts to local practices and traditions and b) knowing the degree to which mothers are likely to follow advice given them; c) mothers themselves contributing answers to how improvements can be made. As CRS/ET staff move to the next step of developing educational materials that focus on the KPC identified areas of need, they might want to support some further diagnostic work in the communities by MCH staff and an outside facilitator to learn from the mothers what are the things they are able to change, which things she now practices can be validated and reinforced, and how and what can be done to make harmless any current practices that presently cause health problems.</p>
--	---

<p>3. Though assuring up-to-date immunizations like antenatal visits are not a function of the MCH itself, the center staff have been effective in checking the children's immunization cards, usually every month, to see that they are up to date. The result is high immunization coverage with half of the center staff interviewed estimating children to be fully immunized at 12 months and the other half, later at 18 months or earlier at 9 months. However, current annotating of the vaccination coverage is inadequate and cannot be "added up" into a meaningful report "% fully immunized by x age". This is because there has been no format provided or method suggested for counting.</p>	<p>3. Uniform reporting should be suggested by CRS/ET with regard to child immunizations. Simplest ways of collecting and reporting coverage rates need to be suggested. It is quite clear that currently children's cards are checked unnecessarily to verify that the vaccinations have been completed when a simple highly visible mark should be made on the card which can then be quickly ignored. Needed is a signal for the right time to record information; one way would be to draw a red line on the cards at the 12th month as a signal to check whether all vaccinations have been completed or not completed, and these would then be totaled up over a three month period for quarterly reporting. If children are completing vaccinations earlier or later than 12 months, the red line should be adjusted accordingly.</p>
---	--

4. Considering the little attention normally given throughout the third world to the "mother" in MCH, successful efforts in CRS/ET centers to enroll pregnant women is highly laudable. Where it has been emphasized (it is being introduced progressively in the program), attention to antenatal visits, tetanus toxoid immunizations and maternal care are working well, especially when mission clinics are adjacent and provide these services (Wonji is an outstanding example of a supportive mission clinic with good relations with the community and government health community, while Meki and Hararghe have problems). In some centers, the concept is in its infancy while in others, staff have a clear picture of keeping pregnant women well with resulting normal birth weight babies and then enrolling the mother/child pair. Because the number of beneficiaries is limited, introducing new pregnant women may appear to compete with new young entrants. In two centers, the magic number of pregnant women is 150 slots which are replaced with other pregnant women when the woman delivers.

4. MCH staff need assistance in estimating the number of pregnant women they should receive. In the more ideal community-based setting, this would not be a problem; all new pregnant women would be eligible, but for the moment some discussions with MCH staff and mother groups are needed to decide what would constitute the right number of places reserved for pregnant women. A first step could be asking the MCH staff to estimate numbers of pregnant women in the communities attending the centers and then an idea of potential coverage could guide on-site discussions. The decision could be made with the peasant associations, development committees, who have developed criteria for selecting priority beneficiaries in other activities. It may be that the allotted numbers per center will require that only "at-risk" women can be taken as determined by a preliminary examination.

5. Outstanding has been the success of moving successfully to age targeting that permits entrants under one only and for the most part by 8 months of age and that graduates children no later than 36 months of age. Many of the center staff are ready to accept out-and-out targeting of under 24 month and have themselves moved progressively in this direction, in at least one case, despite the protests of counterpart staff.

5. New very clear guidelines are needed. CRS/ET can probably safely move to 24 months age limit though there will be protests from some counterparts (MCH staff seem ready to accept these changes understanding more about the growth patterns and the reasons for reducing numbers to the most vulnerable, while counterparts often are more concerned with children they are attached to who still have problems). As all children become graduated at 24 months, some type of incentive should be considered for the mothers who are most successful in keeping their children from growth faltering. They might be invited back and given a small incentive pay for working with mothers who are having problems keeping their children healthy.

6. A study was made of growth faltering in four centers which showed an average monthly incidence of 24% growth faltering. Thus, the benchmark indicator of 30 percent incidence of growth faltering (dropping percentile) per month, appears to be a valid benchmark. The data were taken where time permitted copying entries from center registers, thus did not constitute a representative sampling; they are however, representative of the centers themselves, as they were a 10% random sampling. Though CRS/ET has had a growth faltering objective, they have not yet instituted a system for collecting the data nor trained staff to do it. A form has been prepared, however, to be completed by center staff reporting on numbers (per cent) of children who have gained or lost weight from the preceding month, or stayed the same.

Other small studies made to check growth faltering by season and age group showed no consistent patterns of seasonal incidence, but suggested that growth faltering incidence increases with age.

6. It is recommended that CRS/ET begin collecting information on growth faltering as soon as possible since this has been an objective for several years. The data must be used for learning the specific problems of different regions, seasons and age groups. It should also signal a call for revised inputs if unusually high levels of incidence occur and discussion with the staff about the meaning of the data and the possible remedies for recurring highs or sudden spurts upward in incidence. Staff can easily learn to plot the data as they now do nutritional status, and they should be encouraged to make an occasional graph by age group and keep the entire year in view to see seasonal patterns.

It is suggested that the benchmark indicator of 30 percent be retained for the current center-based program with a target reduction of 20%. For the future community-based program, it is suggested that CRS/ET set a target of reducing the average incidence of growth faltering by 10% in each of the five years of the DAP so that by year five when the program is to end in x community the incidence will have been cut in half.

7. Though there is no baseline data, so that there is no verification that before-and-after changes are attributable to the program, there are dramatic improvements in nutritional status since 1992. Overall center data for 1992 and 1995, and two detailed comparisons of 1992 and 1995 center data for Wonji and St. Anthony's, breaking out an age group, show substantially reduced rates of malnutrition. Teller in 1992 found 84% of children under four to be malnourished (<80% weight for age). King in 1995 found that 46% of children under three were malnourished. Teller found 16% to be severely malnourished (<60% weight for age) while in 1995, only 2.3% were severely malnourished. Because age composition was a factor, children between 13-24 months were separated out for comparison over the two years, 1992 and 1995. In Wonji, 1992 rates of 88% in this age group had dropped to 55% in 1995; in St. Anthony's rates for this age group dropped from 89% to 56%. Severe malnutrition rates dropped in Wonji from 6.7% to 1.1% and in St. Anthony's less dramatically from 2.8 to 2.1.

An illustrative study of age groups suggested an increased prevalence of malnutrition with increased age (the opposite of growth faltering which was found to decrease with age).

CRS/ET has left the surveillance system in limbo while deciding the direction of impact indicators. Confusion from the less demanding proxy indicators accepted for child survival programs--mothers knowledge and practices--and requirements for food-assisted MCH programs still persists among NGOs.

7. Though CRS/ET is undecided about the continuation of the nutritional status compilations, the weighings will continue as the central educational tool, and therefore some level of reporting out the data seems logical. Averages of nutritional status, by age group, for six months or 12 months might be sufficient and save some time in the centers for tallying the growth faltering which would be reported monthly.

Whichever reporting is chosen, the data ought to be used in counterparts' and headquarters' offices to signal problems and deserves feedback on achievements or problems that are occurring. The ACS centers urgently require up-to-date forms with clear percentiles of severe malnutrition. Their excellent work in preparing graphs should be applauded but the changes should be made and they should be cognizant of what the normal range of severe malnutrition is in the rest of the program.

Further study of the growth surveillance data is needed to learn more about what is happening in the different centers which appear to have quite distinct patterns for the age groups as demonstrated in the illustrative study made of 7 centers. Directly affecting factors such as new entrants, graduates and overall age composition also need to be controlled for in making such studies.

8. Since the Teller recommendation that MCH staff have more contact with the community, it appears that many improvements have been made in some, not all centers. Wonji is an outstanding example of how the counterpart has linked up with the community by serving the villages as well, and in places like Hararghe and Gurage where the staff are identified as "animators" for home visits with only functional roles in the MCH. The credit scheme offers another opportunity for linkage with other community mothers and the development committees of the peasant associations.

8. Though home visits are made and some MCH center staff have good community contact, there continues to be a need for a greater depth of socio-anthropological information about the households and women who come to centers. While other food-assisted programs focus on participation of the community in design, the MCH program has been almost all externally imposed; women need to be asked what they would like the rations to be, and why, and they need to inform what they consider priority health subjects for discussion and contribute to the content of recommended solutions.

9. Though sites have been selected by the boundaries imposed by the counterpart infrastructure, the counterparts show a willingness to concentrate, integrate activities in a few areas. The community health model that CRS/ET sees for the future has a better chance of achieving impact because it will be able to follow pregnant mothers through birth and enrollment of children rather than reaching only a certain percentage of each community because of the imposed limitation on number of rations per center now in effect. Working in a single community will also mean having the desired closer contact with traditions and greater cohesiveness of health education content. An adjacent medical clinic for all women and an assured clean water supply will permit the control over participants' environment not now possible. Counterpart staff have demonstrated their ability to change to focussed integrated programs, and the program even in its center-based mode, is moving in the direction of preventive rather than curative.

9. While community-based programs will resolve many of the problems of coverage, cohesiveness, there will still need to be work carried out to get women to participate actively in the design of MCH activities and to know that the programs being offered are time-bound and they must look to the future links to self-sufficiency partially through MCH project components and other community activities. Making women aware of these concepts and identifying real sustainability for the future will be a challenge for counterparts and MCH staff who will need facilitation help supported by CRS/ET and strengthening links with the relevant governmental offices. Regional workshops might be a good plan for introducing the new program, inviting community leaders, health officials and any other NGOs working in the area.

10. The food is shared, but there was a missed opportunity with the addition of the extra kilo to tell the mother all of that must be reserved for the small child. Too little effort is made to convince mothers they should save some of the CRS/ET food for themselves and their smallest children and that this is the purpose of the program, emphasizing that it is health program for the most vulnerable, not food for the family. There are some more difficult months than others for the entire family, those of high diarrheal and malarial prevalence and "hungry" months. Little information is available to draw conclusions on what might work better in the family, but participatory work might reveal a more effective ration directed to a program that will be increasingly one for <2 children and pregnant women.

10. Continued efforts should be made to identify CSB as a high-protein food for vulnerable small children and women in pregnancy. Thought should be given to changing the rations once the program is clearly one for <2 year olds and pregnant women. If the program is totally free of income transfer objectives and devoted to health, the rations should reflect that and be almost exclusively CSB with some oil for calorie-dense preparations, or another similar blended nutritious food for variety, such as wheat-soya-blend (WSB). Several centers are making weaning foods with local food, and the feasibility of preparing these should be studied in the different areas. It might be possible to combine an income generating activity for graduate mothers (preparing and selling the mix to the center); initially, the raw materials might be donated foods (grains, lentils, chickpeas).

11. Major components --immunization of children and maternal care-- depend on access to clinics which may be mission-supported or government clinics. CRS/ET has greatly improved linkages of the MCH with health services since Teller in 1992 made strong recommendations that this be done. Good relations with Government Health officials exist in most areas, though there are currently problems in Meki and Hararghe. Unusually good relations exist in Wonji where a mission clinic nurse has not only provided full support for the MCH clinics but also assists the communities. Some MCH centers with severely malnourished children have access to nutritional rehabilitation centers but not all, and their needs can only be met by being referred to the hospital, an unsatisfactory answer to the problem.

11. CRS/ET should insist that MCH centers have access to counterpart or government clinics that provide maternal care and immunizations for pregnant women and small children. CRS/ET should make it a condition that counterparts will assure linkage with their own or government clinics; where mission clinics exist, they should be required to support the counterpart's MCH programs. CRS/ET should help to reinforce or reestablish relations with the zonal or district health officials where that is needed, as in Meki and Hararghe. Further, these relations can be strengthened and both the counterpart and CRS/ET should take every opportunity to discuss health issues and collaborate. Likewise, where other NGOs such as Save the Children are particularly active in making nutrition or other health surveys, sharing this information is vital.

WOMEN'S CREDIT SCHEME

CONCLUSIONS	RECOMMENDATIONS
<p>1. This program is only one year old and some of the programs only six months old so it is too young to decide about its viability--i.e. can it support its operating costs? And will it continue to be as successful in its later development stages? However, it has met its targets to date and the repayment rate is 99-100% in the four areas where it has been in effect since last December. By September 1995, 810 women were participating in all of the target areas.</p>	<p>1. Consideration should be given to expanding the credit program as a means of meeting the needs of graduating MCH mothers. It is not too early to think of how the credit program might eventually become self-sustaining through community structures outside the MCH.</p>
<p>2. Priorities for participants are somewhat uneven, but there were no complaints heard about inequities. Most MCH and counterpart staff have given preference to MCH women (who have contributed in mothers fees which partially make up the revolving fund) and state they will give preference to graduating mothers (who have already contributed during their time in program and who particularly need the transitional help); others have sought to find the very poor, and in one case, enrolled only mothers of the severely malnourished who were attending a special class. Those groups nearest the MCH center have also been given first chance over those in more remote areas.</p>	<p>2. It appears most appropriate that MCH mothers and graduates be given priority for credit since they have contributed fees for part of the revolving funds. In a community-based setting, the credit program offers the same kind of transition for MCH beneficiaries that soft loans do for former FFW/CFW beneficiaries.</p>
<p>3. Loans have largely been used for initially short-term purchase of grains or vegetables for resale, for buying calves to resell immediately or to fatten and resell over three months.</p>	
<p>4. Profits increase with each subsequent loan. The first--of 100 or 200 birr may results in a profit of only 20 birr or over a few months 40-50 birr, while the second is higher and over a longer term (six months). Most women used the loans for petty trade, for fattening animals, for buying and reselling grain and vegetables.</p>	<p>4. While women have good experience with saving and with taking out loans, they may be hesitant to move beyond traditional trades such as buying and reselling. Assistance with new areas of enterprise might be considered, such as exploring possibilities for involving women in activities that support the MCH program and others in the community by producing reasonably priced high-protein mixes--i.e., marketing or feasibility studies for producing some of the already processed local weaning food mixes for sale in the centers as eventual replacements for CSB.</p>

<p>5. Women said they usually put back into a second loan whatever they had earned on the first. Then, profits accrued at the second or third loan. The profits were used to invest further but also to improve the household --buying kerosene for the cooking, paying school fees, purchasing clothes were most often mentioned. When probed about food, women said they did buy more meat and a greater variety of foods for the home.</p>	<p>5. Indicators of how the profit from loans taken by women affects household food security should be developed if they have not already been formulated--e.g., the percent of increased income that is used to purchase food for the house. Small studies could assess the nutritional status of new children of graduate mothers as a measure of sustainability of the MCH education+ credit package.</p>
---	--

<p>6. What dreams did the women have for the future? Buying a pump to irrigate a plot of land; buying a store in which to sell goods. To do this, they would have to join in a group of 20 or so. The women said their lives were greatly improved and that they did not work harder as a result of these activities; rather arrangements were made for her normal work and then sometimes the activities were less time-consuming than others--petty trade took a lot of time while fattening sheep or cattle took very little</p>	
---	--

FOOD FOR WORK/CASH FOR WORK

CONCLUSIONS	RECOMMENDATIONS
<p>1. Most FFW projects to correct soil degradation have been long term in nature, but are important not only for the ecosystem itself, but for the improvement of agricultural productivity in the future (higher yields). Some of these efforts also have short-term benefits such as planting grass to hold the soil and harvesting it for forage. Also water development activities have immediate results in terms of providing water supply for livestock, human consumption and small scale irrigation.</p>	<p>1. Given the new emphasis of USAID and CRS/ET on early impact in terms of increased agricultural production, it is recommended that FFW environmental protection programs go hand in hand with activities intended to augment crop yields--i.e., fertilizers, improved seed, and better irrigation systems.</p> <p>Impact indicators for forage production and water supply as they relate to food security need to be selected for the new DAP. Forage can be expected to have an impact on home consumption if animals are slaughtered and eaten or sold. Clean water for household use is related to utilization of food, whereas water for irrigation and livestock have an effect on food availability and access.</p>
<p>2. Most of the projects included in the 1994-96 MYOP achieved their projected targets, though it appeared that targets were set according to available foods and that the primary emphasis was on helping needy and subsistence farmers rather than planning for the development of specific assets.</p>	<p>2. In the future, primary planning emphasis should be placed on specific environmental improvements and ways to increase crop production, with incentive payment in cash or kind for unemployed a secondary factor.</p>
<p>3. Over the 1994-96 period, most counterparts selected highly scattered geographical areas for activities because of concerns about equity and the desire to help needy people.</p>	<p>3. CRS/ET and counterparts are already planning integrated community-based projects (catchments and sub-catchments) in many areas which will include environmental protection, increasing agricultural production, water development, improving health and nutritional status of the community, and this is highly recommended as a way of showing short-term and long-term impacts.</p>

<p>4. Technically, the majority of the FFW projects met standards. However, some activities, such as soil bund and micro-basin construction and terracing did not meet MOA specifications strictly. Soil bunds were not as high or compacted as they should have been, the micro-basin beds were not sufficiently raised to hold water and nurture seedling plantations, and micro-basin alignments were not well set. The wattle checkdams, or brush wood checkdams, were placed inappropriately on steep gully slopes and at the bottom of gullies when they should have been built on the actively eroding farm land.</p>	<p>4. Counterpart technicians should be fully versed in manual requirements and follow (supervise the planning and implementation) the projects closely, also working with MOA technical staff whenever possible.</p> <p>Even though wattle checkdams are not technically the best solution for the problems in the Gurage region, there is no other alternative to using brush and sticks because there is no stone for making the preferred type of checkdams.</p>
<p>5. The demonstration and seed multiplication site models are very complex encompassing many agricultural sectors including forestry, horticulture and grass/forage growing, and are questionable models for transmitting agricultural information to local farmers. The sites are more suitable as research demonstration areas.</p>	<p>5. Instead of such complicated activities, it is recommended that counterpart technicians should concentrate on the types of seed production recommended by the Ethiopian Research Institute of crops like wheat, barley and legumes for the highlands and Irish and sweet potatoes and different types of beans for the lowlands. These are likely to be more readily understood and accepted by the local farmers.</p>
<p>6. The selection of projects and sites over the period were made with little input from the concerned communities, reflecting the earlier mentioned tendency to provide jobs for needy farmers in an area. CRS/ET and counterparts have become aware and are teaching participatory methods of planning and implementation.</p>	<p>6. It is recommended that these participatory methods continue and be further enhanced by carrying out socio-anthropological studies to learn why farmers do what they do and which changes they are likely to find acceptable.</p>

OTHER CHILD FEEDING/GENERAL RELIEF

CONCLUSIONS	RECOMMENDATIONS
<p>Current CRS/ET treatment of OCF/GR categories as needy welfare institutions runs the risk of not being approved given the mandates of limiting food aid to beneficiaries who will demonstrate changed status or well being. In fact, the OCF category includes beneficiaries whose status is changed through health care, education or training, and these programs should be separated from the strictly welfare programs. Some programs have arbitrarily been assigned to this category when in fact they are MCH or vocational training and income generating activities.</p>	<p>Facing the realities of priorities under AID's food security mandate, CRS/Baltimore and CRS/ET should develop a new strategy for its OCF/GR programs. One of the first suggestions would be to separate from this category programs that are in fact developmental (income-generating, improving health of women and children, providing skills training) and include them in either MCH or FFW categories (recognizing the problems of different rations) or invent a new category for them on the AER, such as Vocational Training and Skills Enhancement Programs.</p> <p>Overall strategy would seem to require working sessions with the national church structures and local agencies to assist in institutional strengthening and mobilizing alternative funding and food sources for the future although it appears unrealistic to think in terms of becoming self-supporting in the foreseeable decade. This would include developing an institution building strategy that would increase their capacity to broaden their donor base. It would appear advantageous to propose a plan before an ultimatum is presented that would unfairly remove support precipitously.</p>

APPENDICES

DESCRIPTION OF METHODOLOGY.....	2
WORK PLAN.....	4
QUESTIONNAIRES.....	5
PERSONS CONSULTED.....	15
DOCUMENTS CONSULTED.....	20

METHODOLOGY

Following an initial briefing by the CRS Country Representative and Assistant Country Representative, the external evaluators with expertise in maternal child health and agriculture/natural resources, worked with the representatives and CRS/ET technical staff to refine issues in CRS/ET's major project areas during the Multi-Year Operational Plan for Fiscal Years 1994-1996 (October 1993-September 1996) which are:

- ▶ food-assisted maternal child health including growth monitoring, health education, immunization and antenatal control, and credit schemes for women;
- ▶ food- and cash-assisted agricultural extension, environmental sanitation and clean water, soil and water conservation, forestry and infrastructure;
- ▶ food-assisted institutional development in welfare; and
- ▶ on-site feeding of children in institutions

CRS/ET and counterpart technical staff were treated as partners primarily, and interviewees secondarily, in order to keep a participatory approach to the assessment. CRS/ET technical staff traveled with the team further to keep this approach and enrich the results.

The evaluators and CRS/ET staff agreed that purposive sampling was appropriate for meeting needs within the time constraints, and planned visits to the principal counterparts, and to a sampling of project sites representative of MCH and FFW projects within the principal geographic areas of CRS/ET projects emphasis. Within time constraints, sites were selected randomly upon arrival at the geographic areas of the principal counterparts and in the case of OCF/GR, from a list of all of the centers. These were the following:

Geographical Area	Cities/towns	Counterparts	Projects
Addis Ababa	Addis Ababa	Cheshire (NGO)	MCH (Baseline site)
OROMIA (E. SHEWA)	Meki, Wonji and Cheka MCH sites;	Apostolic Vicariate of Meki Nutrition & Development Catholic Church; Wonji Catholic Church.	MCH

2

44

OROMIA (E. SHEWA)	Nazareth	Nazareth Children's Center and Integrated Community Development (NACID)	MCH (Baseline site) CFW/FFW
GURAGE (W. SHEWA)	Emdibir, Dakuna MCH sites; Emdibir Gully Protection; Dinber, Oma and Attat demonstration sites.	Archdiocesan Catholic Secretariat (ACS)	MCH FFW, CFW
HARARGHE DIRE DAWA	Dire Dawa, Jellobelina, Alemshet and Harar MCH sites; Dire Dawa, Fedis, Kombolcha, & Jarso FFW/CFW sites.	Hararghe Catholic Secretariat (HCS)	MCH FFW, CFW
ADDIS ABABA	Addis Adaba	Good Shepherd Family Care Service, Missionaries of Charity AIDS Hospital; Fistula Hospital, Ethiopian Aid; and Abebech Gobena Orphanage and School	OCF/GR

CRS/ET staff assisted with guidance with respect to program status and the identification of key informants, at different program levels and geographical sites. From the suggestions, the evaluation team developed a set of structured and unstructured questions to yield quantitative and qualitative information, obtained from counterparts, line ministries and Relief and Rehabilitative Boards, and project staff. These questions are shown in attachment, along with interview guides used for open-ended focus groups of beneficiaries/participants and community leaders. In addition, data were collected from CRS/ET files and from MCH registers for both representative and illustrative studies related to nutritional status and growth faltering of children.

Primarily the evaluation attempted to provide information regarding how resources have been used and the extent to which project objectives and planned activities were reached or carried out according to the 1994-1996 MYOP and the FY 1995 update. The principal focus was not on identifying problems and inadequacies but rather on formulating lessons learned. The result was a process evaluation, which encompasses an outcome evaluation (to indicate the extent to which planned actions have been completed and how well), and then suggests how programs might be improved. Participants within CRS/ET, the counterpart groups and the community were asked to assist in drawing out lessons that can help program staff improve implementation. To the extent feasible, within time constraints, this "learning process" approach was maintained. Particularly useful was projecting forward with all concerned to a food security framework and how the different projects would link and fit together.

1.

WORK PLAN

Thursday, November 23

PM Arrive Addis

Friday, November 24

Briefings CRS/ET, David Piraino and David Orth-Moore; Amsalu Gebre Selassie and CRS technical staff; work on questionnaires

Saturday and Sunday, November 25 and 26

Informal discussions CRS staff and team member Mamo Mulat

Monday, November 27

Continue discussions with technical staff and work on instruments

Visit OCF/GR program

Tuesday, November 28

Work on field instruments

Visit OCF/GR program

Wednesday, November 29

Visit to Cheshire MCH; OCF/GR program

Thursday, November 30

Visit to Nazareth, MCH and FFW/CFW projects (NACID)

Friday, December 1

USAID; Tom Remington; AIDS day; Visit OCF/GR

Saturday, December 2

Visit to Alebech Gobena Orphanage and School; meet with Mamo

Sunday, December 3

AM Fly to Dire Dawa; Meet with HCS

Monday, December 4 and Tuesday, December 5

MCH visits: Jellobelina, Alemshet, Harar, and Fedis

FFW/CFW visits to Jellobelina, Kombolcha, Fedis and Jarso

Wednesday, December 6

Drive to Nazareth; Plaza Hotel

Thursday, December 7-Friday, December 8

Drive to Meki for MCH visits

Friday, December 8

Drive to Wonji for MCH visits Wonji and Chekar

Saturday, December 9

Complete Wonji MCH visit; return to Addis

Sunday, December 10

Drive to Gurage, briefing by ACS staff; plan program

Monday, December 11-Tuesday, December 12

Visits to Emdiber and Dakuna MCH; FFW/CFW, Emdiber, Dinber, Attat & Oma Zonal Health and Agricultural Office

Wednesday, December 13; Return to Addis by car

Thursday, December 14, Wrap up with CRS/ET; 8 PM Leave for airport

The spaces for answers have been omitted in the following questionnaires.

CHECKLIST FOR COUNTERPARTS

COUNTERPART/LOCATION _____

- CRS Food-assisted programs for which you are responsible?
MCH ☐ GM ☐ Mother Education ☐ Credit ☐
FFW ☐ Ag Prod ☐ Water Sources ☐ Roads ☐ Bridges ☐ Soil Cons ☐ Afforest ☐
CFW ☐ Urban ☐ Rural ☐
Afforest ☐ Land Prep ☐ Weeding ☐ Fertilizer making ☐
Storage facilities ☐ Water Supply ☐ Sanitation ☐
OCF ☐ Orphanages ☐ Other institutions, specify _____
GR ☐ Non-rehabilitative beneficiaries (AIDS, elderly) ☐
Potential graduate beneficiaries (learn skills, get better, lv inst) ☐
- How has (have) the program(s) changed over the past few years? Note the program type, the date first collaborated with CRS and received food, and the principal changes that have occurred over the past few years.

Program Type (MCH, FFW, CFW, OCF, GR)	Date first collaborated with CRS and received food	Principal changes

- (Unless mentioned above), to what extent do those who receive food or carry out work for cash or food participate in the selection of projects, in the planning of the program, or other aspects (specify)
- How would you describe the extent of dependency of those who receive food or cash?
- Organizations also become dependent on programs such as FFW and CFW; do you think your organization is dependent on these programs?
- Aside from handling the food, what are the major responsibilities of your organization and who (with indication of skills brought to task) carries out the tasks for these programs?

Major Responsibilities (4 most important)	Title of the person who handles the task	Skills brought to task(s)

- How were the program options selected. (Why MCH, poverty lending? Why CFW versus FFW or FFW instead of CFW?)
- In the case of FFW/CFW, how and why was the specific technical intervention selected?

The spaces for answers have been omitted in the following questionnaires.

9. Can each technical intervention lead to improved agricultural productivity within five years, or are some longer term?

10. What are problems you consider insurmountable with respect to improving agricultural production? (E.g., livestock overgrazing)

11. Are the food ration or cash wages appropriate for each program? Why (not)? What would you change?

12. Describe how sites and beneficiaries were selected for each program

Program# 1 _____

Criteria for Site Selection	Criteria for Beneficiary Selection

Program# 2 _____

Criteria for Site Selection	Criteria for Beneficiary Selection

Program# 3 _____

Criteria for Site Selection	Criteria for Beneficiary Selection

Program# 4 _____ etc.

13. Effect of food on production and markets.

How do you think the CRS foods brought into the areas of your projects affect clients' own farm production? No effect at all ☐ Probably some effect ☐ Definitely affects ☐ Explain.

FFW/CFW. During the last 12 months, when were FFW/CFW projects active? Encircle months. J F M A M J J A S O N D

Which months are considered idle months as far as farmers' own crop production is concerned? Encircle months. J F M A M J J A S O N D

Do the CRS foods affect prices of foods in the local markets?

14. Local coordination.

How would you describe your working relations with the community?

Poor ☐ Okay ☐ Good ☐ Very Good ☐ Explain (probe for frequency and reason for contact, roles envisaged for counterpart vis-a-vis community).

15. What would be the first priority for improving relations with the community?

16. How would you describe your working relations with the line ministries (health, agriculture, relief and rehabilitation)? Poor ☐ Okay ☐ Good ☐ Very Good ☐

Explain (probe for frequency and reason for contact, roles envisaged for counterpart and the line ministry?)

Health; Agriculture; Relief and Rehabilitation

17. What would be the first priority for improving these relations?

The spaces for answers have been omitted in the following questionnaires.

18. Which NGOs are working in the area on similar activities?
19. How would you describe the quality of your working relations with them? Poor ☐
Okay ☐ Good ☐ Very Good ☐
20. What would be the first priority for improving these relations?

The spaces for answers have been omitted in the following questionnaires.

MATERNAL CHILD HEALTH CENTER

Center and Location _____

staff _____ Names and functions _____

Established when? _____ First received CRS food assistance _____

Check services offered: Growth Monitoring ☐ Health Education ☐ Credit ☐

Maternal Health ☐ Immunization control ☐ Water project ☐

GROWTH MONITORING/FOOD DISTRIBUTION

Infants and Toddlers/Children

1. How many children come each month? _____

2. Can you estimate the percentage of children under one year of age? _____

3. At what age may children enter the program? <4 months ☐ 4-8 months ☐

Other ☐ Specify _____

4. When do you graduate children? By 24 months + children still <80% W/A but under 36 months ☐ by 36 months ☐ other _____

5. Do you have any problem determining who is eligible? No ☐ Yes ☐

If yes, describe: _____

6. Can you estimate the number of children who are fully vaccinated by different ages: 9 months of age ☐ 12 months of age ☐ by 24 months of age ☐

Percentage _____

7. If the child is not up to date on immunizations, what do you do? _____

8. Do you have a vaccination schedule? Yes ☐ No ☐ Check it. (If no), how do you know if the vaccinations are up to date? _____

9. What percentage of the children last month were faltering in growth (staying the same or losing weight)? Knows what this means ☐ Can estimate for last month ☐ The percent for October 1995 is _____

10. What do you do if a child is growth faltering? (Home visits, rehab center?) _____

OBSERVATION

Weighing Techniques

Age calculating:

Scale calibration

Scale reading to 100 gm

Correct recording

Eye contact

Content counsel

Attitude counsel

Very Poor

Poor

OK

Good

Excellent

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

Note whether staff are recording specific vaccinations. Yes ☐ No ☐

Comments: _____

Check growth charts on file. Where there is time, make illustrative studies of patterns of growth faltering, ages at entrance, graduation.

Health Education. Observe if possible: 1) food demonstrations; teaching/education of women Describe content, techniques, participation and interest of women, length of

The spaces for answers have been omitted in the following questionnaires.

session:

Food Distribution (Observe condition and amounts of food provided, flow)

1. How much food did each mother receive last month?
(Per beneficiary) 2.5 Kg wheat ☐ 3 Kg CSB ☐ 1.5 liter oil ☐ Other: _____
2. How much does she normally receive (previous month)?
(Per beneficiary) 2.5 Kg wheat ☐ 3 Kg CSB ☐ 1.5 liter oil ☐ Other _____
3. Do you know how the food given here is used in the house? No ☐ Yes ☐
If yes, who eats each type? Wheat? _____ CSB _____ Oil? _____
4. Who are the most vulnerable members of the family? What do you advise mothers about the needs of vulnerable members?:
5. How long does the food rations given here usually last?
Average number who eat in the home?
Are some months different from others?
6. What suggestions would you make for changing the weighing and food distribution program?

Pregnant Women

1. How many pregnant women are enrolled _____ A year ago if available _____
2. How many women came last month? _____
3. How many women receive food supplements? _____
4. Besides giving food supplements, what do you tell women?
5. Do you suggest ante-natal visits for pregnant women? Yes ☐ No ☐
(If yes), what do you suggest ☐ require ☐ with regard to ante-natal visits?
At least 3 visits ☐ Other _____
6. How do you follow up on this suggestion or requirement? Withhold future food supplements ☐ give warning ☐ other _____
7. Do you think more women going for ante-natal visits than 6 months ago?
8. Do you think the food is needed to bring women for antenatal care (if adjacent to MCH)?
9. (If they are told to go to an MOH center), Do you think it is sufficient incentive for women to use the health services?
10. Would you attend health services without the food?
11. Are there problems with health services provided?

Mother fees

1. Are mothers able to provide 3 birr a month? Yes ☐ No ☐ Comment:
2. Do you think mothers should help to decide how the fees (1.5 Birr each month per person) are spent?

POVERTY LENDING

1. When was the credit program started?
2. Who is eligible? Mothers in MCH program ☐ Women from this community? ☐
Women from nearby communities? ☐ Other:
3. How many women have taken first loans? _____ second? _____ third? _____

The spaces for answers have been omitted in the following questionnaires.

4. How many have repaid their loans? are in arrears?
5. What are most loans used for?
6. How long do you think it takes for loan benefits to bring about increased income?
7. Has increased income led to improved food in the house?
8. Are there changes needed to make this a better program?

Wells/Clean Water

1. How many of the mothers do you estimate have clean water?
2. Do you intend to ask for projects which would improve water supply? (Hand-dug wells)? _

INTERVIEW GUIDE FOR MOTHERS FOCUS GROUPS

1. Note presence of non mothers: fathers, grandmothers, Others _____
2. How long have you been in the program?
3. How much food did you receive last month (or the last time you came)
(Per beneficiary) 2.5 Kg wheat ☐ 3 Kg CSB ☐ 1.5 liter oil ☐ Other: _____
4. Do you think you received your full ration of Wheat 2.5 kg? CSB, 3 kg?
Oil, 1.5 Liter?
5. How long did it last? _____
6. How many eat in your home? _____
7. Does the family share all of the foods?
8. Are some reserved for your children?
9. Do you belong to a credit association? Yes ☐ No ☐ If yes, have you taken loans?
One? _____ Two? _____ Three? _____
10. What have you used the loans for?
11. Do you earn more income now? Yes ☐ No ☐ Can you estimate how much?
12. If yes, What do you spend the extra income on?
How much would you say for food?
13. Do you have more food available now? _____ Do you buy more of some foods?
Which foods?

The spaces for answers have been omitted in the following questionnaires.

OTHER CHILD FEEDING/GENERAL RELIEF

Counterpart/Institution _____ Location _____

Founded when? _____ Main objective: _____

Types of services: Educ for Young ☐ Health ☐ Skills Tng ☐ Help for Non-Rehabilitative

☐

1. First received food from CRS _____
2. How is it used? : dry rations for use at home ☐ on-site feeding ☐
3. What amounts of food do you receive per eligible person?:
OCF client CSB 2 kg ☐ wheat 4 kg ☐ oil 1 ltr ☐
GR client CSB 2 kg ☐ wheat 10 kg ☐ oil 1 ltr ☐
MOC client Bulgur 10 kg ☐ plus 7.5 kg other ☐
4. Number of participants/beneficiaries _____
5. Principal Characteristics: Age group _____ physical characteristics _____
6. How did you select the participants/beneficiaries? Made surveys ☐ Visited Homes ☐

decided based on established criteria ☐ What are the criteria?

REHABILITATIVE

7. Are there any of your original beneficiaries who have graduated?
8. What is the average time participants/beneficiaries remain in the program?
9. Based on what criteria do they leave the program?
10. Do you follow up on former clients when they leave the institution? Yes ☐ No ☐
If yes, what do you consider to be their current degree of independence?
11. Is there a waiting list of families or individuals who would like to be in the program?

GENERAL

12. Who are your donors? How diverse is your funding base?
13. Do you undertake active fund-raising? Yes ☐ No ☐ If yes, describe:
14. Do you have income generating activities? Yes ☐ No ☐ If yes, describe:
15. What can be done to enhance these fund-raising and income-generating activities?
16. What are your problems?

The spaces for answers have been omitted in the following questionnaires.

CASH FOR WORK - FOOD FOR WORK TECHNICAL PROJECT STAFFS

Descriptive

A. Population of the Project

area: _____

B. No. of Livestock: cattle _____ sheep & goats _____ equines
_____ poultry _____

C. What percent of land is under cultivation? _____ grazing? _____ forested? _____ gullies,
denuded areas? _____

1. What were the criteria for selecting the project site(s) selected? Food deficit area

☐ Other _____

If a food deficit area, how did you determine it was food deficit? Made a needs
assessment ☐ chronic drought area ☐ chronic erosion area ☐ other ☐ specify:

How were the project participants selected?

2. What other technical criteria were used to select the project (s)? Heavy erosion

☐ drought ☐ population density ☐ size of land holding ☐ low-yielding agricultural
production ☐ Other?

3. Did members of the community participate in the formulation of the project and
the project site? Who participated?

4. How did they participate? Diagnosing ☐ Planning/project design ☐
implementation ☐ monitoring ☐ other ☐, specify:

5. What were your project targets for 1994-1995?

6. To what extent did you meet them?

7. What has been the change in agricultural yield because of cropland conservation
measures?

8. Are there reasons for a high or low yield?

9. What do people think about conservation activities? (Do they accept them?)

9a. What do people think about the construction of bunds?

9b. What do they think about tree planting?

10. Why was FFW or CFW selected for this project?

11. Which do the people prefer and why?

12. What percentage of the population would you estimate receive FFW or
CFW? _____

13. How long have people received FFW on the average?

14. Do you think people have become dependent on the food or cash? Why?

15. Who is in charge of paying the cash? Or of delivering the food?

15a. Does the community have a voice?

15b. Is this done properly and efficiently?

16. How often are farmers/workers paid? Are they paid on time?

17. Are the norms and schedule of payment appropriate?

18. Have project conservation areas been cared for after the end of each year's

The spaces for answers have been omitted in the following questionnaires.

activities?

- 18a. How is it managed at this time?
- 18b. Who will take care of the future management of the conservation areas?
- 18c. What use should be made of the project conservation area?
- 19. Have there been examples of deliberate destruction of projects completed?
- 20. What are the most important improvements that should be made in these programs to improve their fairness and effectiveness?

FOCUS GROUPS: FARMERS/WORKERS

- 1. Which project (s) have you worked on?
- 2. Were you paid in cash or food? Cash N= ____ Food N= ____
- 3. Which would you prefer? And why?
- 4. How long did you receive food or cash?
- 5. Do you know why food or cash was given?
- 6. What difference did it make in the food available at home? (If food), how long did the food last at home?
- 7. Were you paid in food or cash on time?
- 8. What do you think about conservation activities?
- 9. What do you think about tree planting?
- 10. Can you think of a better way to conserve the land? How do you think these programs can be improved?

PERSONS CONSULTED

CRS/BALTIMORE

Valarie Barksdale, Public Donor Relations, Office of Project Resource Management (OPRM)
Lisa Kuennen (telephone), OPRM
Michael Frank, OPRM
Jindra Cekan, Food Security Adviser, OPRM
Ruth Harvey, Health Technical Adviser, OPRM
Tom Remington, Agricultural/Natural Resources Technical Adviser (in Addis Ababa)

CRS/ETHIOPIA

David Piraino, Country Representative
David Orth-Moore, Assistant CR
Regular Title II Programming:
Amsalu Gebre Selassie, Manager Title II Program
MCH, Emebet Admassu
MCH, Tamaru Kassa
MCH/Credit, Tsainesh Mesele
MCH/Credit, Tsainesh Adnew
FFW/CFW, Moges Worku
FFW/CFW, Mesele Endalew
Welfare (OCF and GR), Wondim Haille Marian

USAID/ETHIOPIA

Marge Bonner, Director
Herbie Smith, FFP
Carrel Laurent, FFP
Ato Shewengizaw, FFP

ETHIOPIAN CATHOLIC SECRETARIAT

Brother Gregory Flynn, Welfare and Development Department

GOOD SHEPHERD (FAMILY CARE SERVICE)

Mulugeta Abebe, Managing Director

MISSIONARIES OF CHARITY AIDS HOSPITAL

Sister M. Niharica

FISTULA HOSPITAL, ADDIS ABABA

Dr. Steve and Jan Arrowsmith

CHESHIRE MCH

Nigussie Wolde Selassie, Coordinator
Mekonnen Temesgen
Haile Gabriel Semu

NATIONAL CHILDREN'S CENTER AND CENTER FOR INTEGRATED DEVELOPMENT (NACID), Nazareth

Mr. Teferi, Project Manager
Mr. Tefera, Program Coordinator
Mr. Assefa, Deputy General Manager

MCH

Mr. Belacho, MCH Director
Focus Group of women at MCH Nazareth
Sister Tsadkaw G. Hiwot, head of polyclinic
CFW latrine and waterpoint projects in Nazareth
FFW pond and bunds, 20 km north of Nazareth
Focus Group of FFW participants
Focus group of women of credit association, Tede
Mrs. Aselefech, Chair

ETHIOPIAN AID

Haile Shemer, Deputy Project Coordinator

ABEBECH GOBENA ORPHANAGE AND SCHOOL

Taye Demissew, Project Coordinator

HARARGE CATHOLIC SECRETARIAT (HCS)

Abba Tesfaye Debas, Diocesan Development Coordinator

Brother Kifle Mariam, Assistant Coordinator

Belihu Negesse, Agricultural Coordinator

Wondwosen, Nurse

Taye, Credit Coordinator

Harar FFW Expert for Kombolcha/Jarsso Woredas, Mr. Teodros, Agricultural
Technician

Abdella, Fedis Agricultural Coordinator

Fedis MCH

Adisu Tarekegne, Contact Person

Estifanose W/Micheale, Team Leader

Eriste Demese, Registrar

Mesfin Daddesa, Weigher

Jellobelina MCH, outside Dire Dawa
5 MCH Staff members
Focus Group of 25 women from Adaba.

Alemshet MCH, in Dire Dawa
Ababa Abayenh, Contact Person
Medhine Kifle Mariam, Team Leader
Assumta Petros, Registrar
(Weigher and distributors absent)

St. Anthony's MCH in Harar
Tilaye Bogale, Contact Person
Almaz Zegye, Team Leader
Matiose Argow, Registrar
Almaz Gobena, Weigher
Affende Mume, Kure Garedow, Yewebdaren Alula, Distributors
2 Focus Groups of MCH women

MEKI CATHOLIC CHURCH

Mr. Robert Griger, Diocesan Development Coordinator
Public Health Nurse/Midwife Marie Mulvey
Public Health Nurse/Midwife Elizabeth Barry
Meki MCH and Income Generating Projects
Focus Group of Meki MCH Women

WONJI CATHOLIC CHURCH.

Father Visconi
Sister Antoine Brahana Selam, MCH Director
Sister Celestina Nnad, Medical Center

Wonji MCH

Argaw Woldeyesus, Team Leader
Sara Yohannis, Weigher
Tamirat Tefera Accountant (former Coordinator)
Food Distributors Habnesh Etheta, Tsye Gulma and Winke Geda
Focus Group of MCH women

Cheka MCH (13 Km from Wonji)

Desalesn Lerazo, Contact Person
Mulimesh Nuranu, Team Leader
Lemgnesh Gorgese, Cashier
Aynalem Alemu, Weigher
Food distributors Turenesh Mathouse, Aberesh Zekemose, Grimu Demusse,
Focus Group of Mothers, Cheka MCH

ARCHDIOCESAN CATHOLIC SECRETARIAT/ACS, GURAGE

Tesfaye Shinkur, Project Coordinator
Radwan Kornima, Ag Technician
Sister Tenanesh Antoni, MCH Coordinator
Yohannes Yoseph, FFW Coordinator
Menur Mesgene, Ag Technician
Yoseph W. Michael, Agronomist
Abdella Yasen, Natural Resources Expert

Emdibir MCH Animators

Alemtshay Franswa, Contact Person
Elina Dinku, Registrar
Tewabech Terka, Weigher
Geizaw w/Mariam, Animator
Aschenaki Mraga, Animator
Focus group of mothers Emdibir MCH

Dakuna MCH Animators

Dula Abshevo, Contact Person
Kibatu Demisis, Weigher
Distributors:: Triku Zeriga; Mulushwa Ergete
Focus group of mothers Dakuna MCH

Zonal Officials, Wolkitte

Mr. Sisaye Mamo, Zonal Head of Agriculture
Dr. Mitiku, Zonal Head of Health
Mr. Alemu, Assistant Zonal Head of Health

DOCUMENTS CONSULTED

1. Catholic Relief Services/Ethiopia, Title II Multi-Year Operational Plan (Regular Program) FY 1994-96, submitted to USAID, 2 May 1993.
2. Catholic Relief Services/United States Catholic Conference (CRS/USCC), an Assessment of P.L.480 Title II Maternal Child Health Programming: Directions for High-Impact Health Programs, Technical Group Paper, Vicki M. Denman 1995.
3. Cekan, Jindra and Payton, David, Title II Survey of General Welfare and Other Child Feeding Programs in Ethiopia and Kenya, May 1995.
4. CRS/Ethiopia 1996-98 SPP Concept Paper, November 23, 1994.
5. USAID/Ethiopia, Concept Paper, "Back to the Future" May 12, 1993.
6. Catholic Relief Services/Ethiopia, Title II Multi-Year Operational Plan (Regular Program) FY 1994-1996, 2 May 1993.
7. Teller, Charles H. et al., Collaborative Assessment of the CRS Maternal /Child Health (MCH) and Nutrition Programme, Addis Ababa, March 1993.
8. Catterson, Thomas M. et al., Natural Resources Management and Title II Food Aid: An Evaluation, USAID/Ethiopia, December 1994.
9. CRS/Ethiopia, FY 1995 MYOP Update, April 26, 1994.
10. _____ FY 1996 Annual Action Plan Title II Regular Food Program
11. _____ Emebet Admassu et al, Report on Health Knowledge, Practice and Coverage Survey, Adama and Lume Districts, Nazareth (NACID), June 1995 Addis.
12. ^{Tshaimedh mesele} _____ Emebet Admassu et al, Report on Health Knowledge, Practice and Coverage Survey, Cheshire, 1995, Addis.